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ABSTRACT

Despite increasing interest on the part of minority undergraduates and a potentially expanded applicant pool, minority admissions to most health professional schools have remained static or fallen since 1974-75. Although women are being admitted to medical schools in increasing numbers, they still constitute less than thirty percent of the student population. Federal financial aid policy plays a role in perpetuating a bias against women and minorities by focusing funding on service commitment scholarships that are awarded without regard to financial need, race, or sex. The most affluent students receive, on the average, fourteen percent more than the poorest students. Affirmative action for minorities appears to succeed where affirmative action has also succeeded for women. However, a pattern of discrimination against women seems to be evident in southeastern medical and dental schools. The most important component of a successful affirmative action program is involvement of minority students and faculty in admissions and retention programs. Yet the percentage of minority faculty has not changed since 1971-72. Numbers of black and Puerto Rican faculty in medical schools have declined. (Author/APM)

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DOUBLE INDEMNITY

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Double Indemnity:

The Poverty and Mythology of Affirmative Action in the Health Professional Schools

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A Health/PAC Special Report

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Finally and most important was the personal support we received from Janet Goldmark and Ann Umemoto.

We hope that this collective process continues as our readers, in turn, draw strength from this study for their efforts to support and sustain affirmative action.

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PART I
FINANCIAL BARRIERS TO EQUAL REPRESENTATION FOR MINORITIES IN THE HEALTH PROFESSIONS

Buried in the back pages of the mammoth Sunday *New York Times* on April 22, 1979 was the report of the Department of Health, Education and Welfare's general counsel that its numerous civil rights and affirmative action programs for minorities were "almost entirely unaffected" by the Supreme Court decision in the infamous *Bakke v. Regents of the University of California*. During the entire year before the June 1978 decision, *Bakke* dominated the headlines and covers of such influential publications as *Saturday Review*, *The Atlantic* and the *New York Times Magazine*. (For the Health/PAC assessment, see *Bulletin* No. 76, May/June 1977, and its special report, *The Myth of Reverse Discrimination: Declining Minority Enrollment in New York City's Medical Schools* by Barbara Caress.) The Court's decision — straddling more positions than nine acrobats — found Allan Bakke entitled to a seat at the medical school of University of California-Davis because the school's special admission process for disadvantaged applicants violated Title VI of the Civil Rights Act of 1964. But, the Court said, consideration of race among other factors was permissable in the admissions process.

The most publicized Supreme Court case of the decade has fallen into obscurity; its purpose served a legal diversion while many of the necessary fiscal supports for affirmative action have been dismantled. During the time when professional education allowed its affirmative action programs to be kept on "Hold" by, first, *DeFunis v. University of Washington*, and then *Bakke*, the backlash generated still more litigation and legislation.* The decisiveness of *Weber v. Kaiser Aluminum and United Steelworkers Union* may still the opposition's use of litigation in employment. Increasingly, legislation has been the chosen route, effective in often subtle and remote ways. Wherever possible, opponents of "reverse discrimination" will cut, trim, or tax the social wage being demanded and paid for past discrimination.

When HEW's general counsel finds almost nothing affected by *Bakke*, the message is clear: either affirmative action has already been undermined to such an extent that *Bakke* could do no further harm, or the *Bakke* decision was more important as a media event than it was as law. For the health professions both are true. The anti-affirmative action backlash combined with the forces of inflation, changes in federal health manpower and financial aid policy and institutionalized myths and racism have broken and turned the momentum of affirmative action as well as the opportunity and rationale for the health professions to suspend their largely ineffectual and ambivalent efforts at minority recruitment. This year the percentage of minorities newly entering health professional schools has declined to levels of ten years ago when pressures for affirmative action were just beginning. Moreover, a comparable limit upon women entering the health professions can also be seen on the horizon (1).

Just as the subtlety of oppression grew when the civil rights movement turned from southern *de jure* to northern *de facto* discrimination, resistance to affirmative action moves deeper into its racial and class roots as the struggle moves from openly racist and sexist practices to those of professedly liberal institutions and the economy changes from expansion to contraction and inflation. As "gatekeepers" for both professional doctrine and entrants, the health professional schools have responded to the market demands for limits, orthodoxy, fiscal austerity and elite control. Admission to health professional school is as difficult today as ten years ago.

A Brief History of Affirmative Action

Affirmative action is rooted in political and social movements. FDR's Fair Employent Practices Commission was created in 1941, following

*One such piece of legislation was the "Walker" Amendment to the 1979 Labor-HEW Appropriations Bill. This bill would have prevented HEW from implementing numerically-based affirmative action programs, its legal mandate. Fortunately, it was deleted by the Senate-House Conference.

a threatened march on Washington by A. Phillip Randolph and other Black leaders. The presidential directive ordered an end to racial discrimination in federal hiring, with the Fair Employment Commission empowered to investigate compliance with the order.

Amid a renascent civil rights movement in the 1960s, President Lyndon Johnson extended equal employment coverage through Executive Orders 11246 and 11375. These Orders prohibit discrimination in employment by all employers holding federal contracts, and require affirmative action programs by all government contractors and sub-contractors receiving contracts of more than $50,000 and employing more than 50 persons. Title VI of the Civil Rights Act of 1964 forbids discrimination against students on the basis of race, color or national origin. Title VII of the Act, as amended by the Equal Employment Opportunity Act of 1972, forbids employment discrimination on the basis of race, color, national origin, religion or sex by any employer of fifteen or more persons, public or private, whether or not they receive federal funds.

The first federal sex discrimination legislation, the Equal Pay Act of 1963, was also enacted in response to the civil rights movement. It requires equal pay for equal work regardless of sex. In 1972 this was extended to cover executive and professional employees, including college and university faculty.

In 1974 there was one white physician for every 560 whites in the population, but only one Black physician for every 2,800 Blacks, five times worse than the ratio for whites. In 1974, there was one white dentist for every 2,500 whites, but only one Black dentist for every 12,500 Blacks. These ratios for Blacks are worse than those of the 1940s!

Compliance with federal civil rights orders and statutes has been undermined by inconsistent and confused regulations issued by the bureaucracies involved and by numerous, contradictory court orders. Considerable interagency conflict between the Departments of Labor, Justice and HEW and the Equal Employment Opportunity Commission have diluted the responsibility for monitoring and enforcing anti-discrimination guidelines. Only in September 1978 did these agencies publish uniform guidelines for employee selection procedures. The guidelines assert that any test or other selection procedure which has an adverse impact on minorities or women is illegal unless test performance can be clearly shown to predict job performance. Where statistical evidence of on-going employment discrimination exists, institutions are only asked to document that good faith has gone into the effort to recruit women and minorities, not necessarily that progress has been made toward integration.

The pertinence of these legal mandates for the health professions is profound, given their historical discrimination against minorities and

As recently as 1963, five American medical schools were still officially closed to Blacks

women. As recently as 1963, five American medical schools were still officially closed to Blacks (2). Not until 1964 did the American Medical Association vote to prohibit racially discriminatory membership policies (3). UCLA did not graduate its first Black dental student until 1974 (4). As recently as 1965 the National Dental Association claimed that in eleven southern state organizations the American Dental Association "only rarely accepted Negro members" (5). Full, open membership did not arrive in the American Nurses Association until 1964, although some Black nurses were allowed ANA entry in 1951 (6).

Now, more than twenty years after *Brown v. Board of Education* made segregated education illegal, the health professions continue to perpetuate racial discrimination. This contributes to the appalling imbalance between the physician-population ratios of whites and Blacks — in 1974 there was one white physician for every 560 whites in the population, but only one Black physician for every 2,800 Blacks, five times worse than the ratio for whites. Similarly in 1974 there was one white dentist for every 2,500 whites, but only one Black dentist for every 12,500 Blacks (7). These ratios for Blacks are worse than those of the 1940's! (To be sure, in some instances white doctors treat Black patients and vice versa, but the pattern of white

doctor-white patient and Black doctor-Black patient is still pervasive, particularly in primary care settings.)

As the civil rights movement reached higher education, a task force consisting of the Association of American Medical Colleges (AAMC) and a consortium representing the AAMC, AMA, American Hospital Association and National Medical Association announced in April 1970 an objective of 12 percent "representative" minority enrollment in American medical schools by 1975 (8). The AAMC included Blacks, Hispanics and Native Americans in its minority enrollment goal.* The 12 percent figure, however, was roughly the percentage of only Blacks in the US population in 1970. The percentage of Blacks, Hispanics and Native Americans combined in the US population then was about 16 percent, actually the more "representative" goal for the AAMC.

Not until 1964 did the AMA vote to prohibit racially discriminatory membership policies

Later figures show that American medical schools fell far below this modest 12 percent goal, not to speak of the 16 percent figure. Specifically, minority enrollment increased from about 5 percent in Academic Year 1971-72 to a peak of 8.2 percent in Academic Year 1974-75. Since then the figure has levelled off at about 8 percent (see Figure 1).

Full, open membership did not arrive in the American Nurses Association until 1964

The 1970 AAMC report made several additional recommendations: substantial increases in and coordination of financial aid to minorities; the creation of an "educational opportunity bank" and a network of regional centers to provide health career counseling for minority students, and expansion of the AAMC's Office of Minority Affairs, established in 1969 with grants from the US Office of Economic Opportunity. Seven years later, only the last goal was achieved according to an HEW-commissioned evaluation (9). This was largely due to a $1.5 million OEO grant to administer some 50 programs for minority students from 1969 to 1973.

A 1978 report from the AAMC now suggests that minorities will have to wait until the year 2000 for parity! (10). Although the report comments upon the federal withdrawal of support for minorites, both fiscally and philosophically, its seven goals focus upon the various steps (and, therefore, "hurdles") which minorities encounter along the path to becoming fully trained physicians. The report largely points the finger elsewhere for the failure of medical schools to achieve their own objectives.

The AAMC report was published during the same month that the Supreme Court announced the *Bakke* decision. Recently, similar concerns have been shown for minorities in dentistry.

A 1978 report from the AAMC now suggests that minorities will have to wait until the year 2000 for parity!

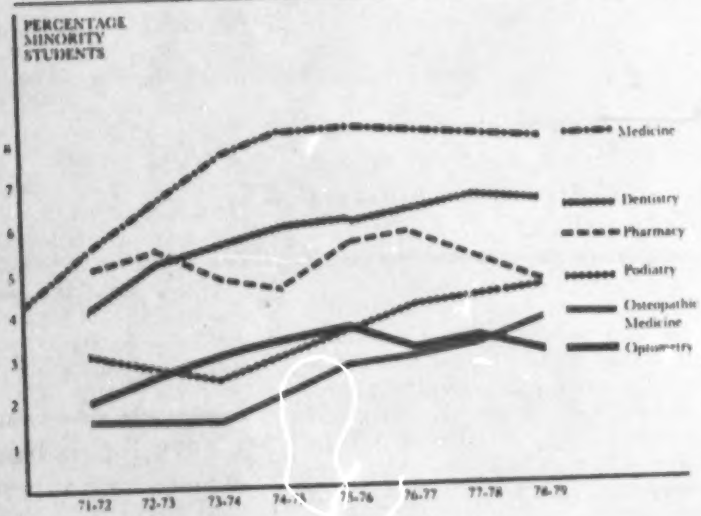
Both professions plead the traditional case, bemoaning the poverty and discrimination which have left them too few qualified minority candidates for achieving parity. This is really out of their hands, they say. So under the guise of "professional standards," the buck is passed again.

The Rise and Fall of Affirmative Action

Political pressures from the civil rights and women's movements have produced substantial gains in the numbers of minority and women students being trained in the health professions. These gains can be found prominently displayed in each field's publications, demonstrating the profession's "good faith" in seeking parity for minorities and women.

*Asian minority groups were not among the populations included in the AAMC affirmative action programs because they are not generally underrepresented in the heath professions compared to their proportions in the general population. However, they do suffer discrimination and racism in the health care system as in other aspects of American life. When not otherwise designated, minority group data in this article includes Blacks, Hispanics [specifically mainland Puerto Ricans and Mexican Americans (Chicanos)] and Native Americans, reflecting the AAMC data.

Figure 1
Percentage of Under-represented Minority Student Enrollment in Selected Health Professional Schools, 1970-71 to 1978-79



Sources: Johnson, Davis G. and Gordon, Travis L., "Datagram: Medical Student Enrollment, 1974-75 Through 1978-79," *J Med Educ* 54: 431-433, May 1979.
Philpot, Wilbertine P., *Minorities & Women in the Health Fields: Applicants, Students and Workers*. DHEW Publication No. (HRA) 79-22, October 1978.
Annual Educational Surveys, 1978-79, American Dental Association, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, and Association of Schools and Colleges of Optometry.

But the accomplishments are in most cases meager. Consider the traditional health professional schools of medicine, osteopathic medicine, dentistry, optometry, pharmacy and podiatry. (Nursing provides a more complicated picture, which will be addressed in a future Health/PAC Report.) Of the various professional schools listed in Figures 1 and 2, minority student enrollment and Black student enrollment have substantially increased in only one (podiatry) since the Academic Year 1974-75 (that is enrollment has increased by at least one percentage point). In the other schools, minority and Black student enrollment have remained essentially constant or dropped slightly since then. Especially serious is the trend of decreasing Black enrollment since 1974 in the two largest of the professional schools, medicine and dentistry. Still lower levels of minority student enrollment continue in schools of osteopathic medicine, optometry and podiatry.

Within the field of pharmacy, the single field where a recovery is being made, almost all the improvement is accounted for by the four primarily Black pharmacy schools: Howard, Florida A&M, Texas Southern and Xavier Universities. These four programs account for more Black pharmacy students and graduates than all 68 predominantly white institutions combined that collectively enroll less than two percent Black pharmacy students!

A parallel problem of uneven progress plagues medicine, too. Walter F. Leavell, MD, chairperson of the AAMC minority affairs section reported to medical educators attending the AAMC Group on Student Affairs meeting in November 1979 that 53 percent of the minority medical students are concentrated in only 38 of the nation's predominantly white medical schools, while 83 schools (or 69 percent) enroll only 47 percent of the minority students. In the fall of 1978 five medical schools had no minority students (11)!

While progress toward parity for minorities in the health professional schools is usually discussed in terms of total minority enrollment, these figures are not the most sensitive to changes in the student body. First year enrollments are frequently presented as trends by representatives of the professions, like the AAMC, typically inflated by including all repeating and re-enrolling minority students.

The key issue is whether institutions are actively recruiting and retaining new minority students. If they are not, minority enrollment figures will inevitably fall in the future. The most sensitive indicator of minority participation in a field is the percentage of the first year enrollment of *new* minority students admitted and matriculated, excluding repeaters and re-enrollees.

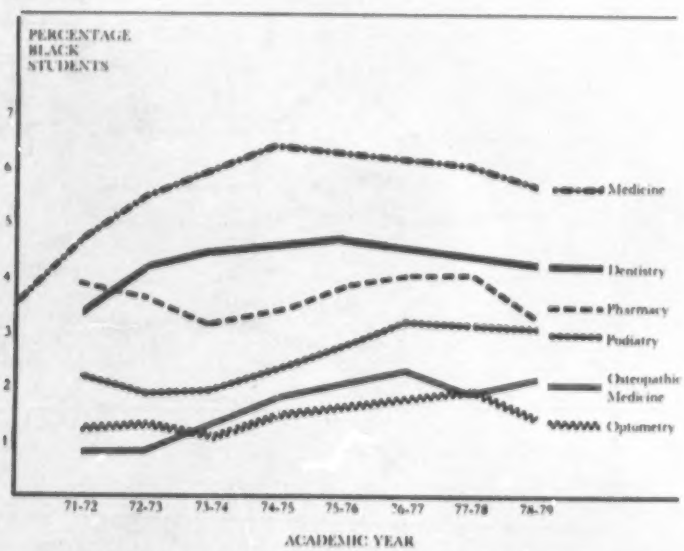
The data for these minority student admissions are revealing. With the exception of Academic Year 1974-75, minority admissions to the first year of medical school *have hardly changed since 1971*, when the AAMC affirmative action program began (see Figure 3). What's more, Black student admissions to medical schools, again with the exception of 1974-75, have been *falling* steadily since 1971-72 (Figure 3). The current rates of Black medical school admissions are well below the 1971 levels!

As for dentistry, total minority admissions rates have climbed very slowly since 1971-72, but for the last three years they have stagnated at 6.8 percent. Black student admission rates, however, have slowly but steadily *declined* since 1971-72. Osteopathic medicine doubled its very low minority admission rate between 1973-74 and 1974-75. This level of admissions has been maintained for all under-represented minorities, but not for Blacks, whose percentage in the first year enrollments has declined since 1974-75 (Figure 3).

. . . 53 percent of the minority medical students are concentrated in only 38 of the nation's predominantly white medical schools, while 83 schools (69 percent) enroll only 47 percent of the minority students. In the fall of 1978 five medical schools had no minority students

Thus according to this more sensitive indicator, the admission rate of new minority

Figure 2
Percentage of Black Student Enrollment in Selected Health Professional Schools, 1970-71 to 1978-79



Sources: Johnson, Davis G. and Gordon, Travis L., "Datagram: Medical Student Enrollment 1974-75 Through 1978-79," *J Med Educ* 54: 431-433, May 1979
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Annual Educational Surveys, 1978-79, American Dental Association, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, and Association of Schools and Colleges of Optometry.

With the exception of Academic Year 1974-75, minority admissions to the first year of medical school have hardly changed since 1971.

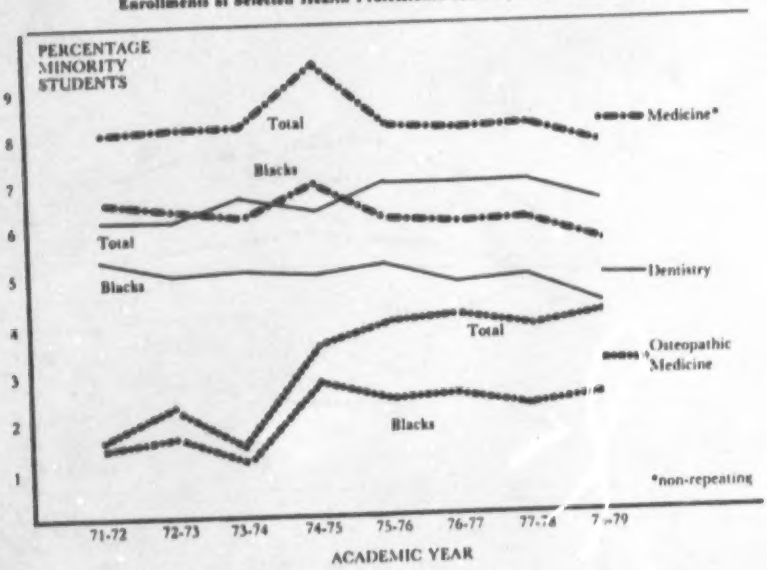
students, the much heralded affirmative action programs of the AAMC have had little impact on minority admissions. And since the inception of this program in 1971, representation of Black students in these health professional schools has actually *dropped*. The enrollment figures used by the AAMC obscure this failure, but they will do so only temporarily—eventually, if present trends continue, these figures too will reflect the drop in Black admission rates and the stagnation in overall minority admission rates.

The worsening situation for Blacks is also reflected in the declining percentage of Black applicants accepted to medical schools (Table 1).

The enrollment of women in health professional schools presents, so far, quite a different story. In every one of the six types of schools reported there has been a steady, significant increase in the enrollment of women (see Figure 4). For example, enrollment of women in medical schools more than doubled between Academic Years 1971-72 and 1978-79, from about 11 percent to 24 percent, respectively. In optometry, female enrollment jumped from about 4 to 15 percent during the same time period. Freshman admission rates for women and minorities by individual medical school—the best and worst of them— are given in Table 2.

Only recently have trends suggested a ceiling for women entering medicine. During the last two years the number of women applying to medical schools has decreased, while current admission rates for men and women remain nearly identical. The percentage of women entering medical schools actually fell slightly from 1977-78 to 1978-79 for the first time since the early 1950s. This decline in applications would suggest a plateau of less than 30 percent of

Figure 3
Percentage of Black and Total Under-represented Minority Student First Year Enrollments at Selected Health Professional Schools, 1971-72 to 1978-79



Sources: Philpot, Wilbertine P., *Minorities & Women in the Health Fields: Applicants, Students and Workers*. DHEW Publication No. (HRA) 79-22, October 1978.
Annual Educational Surveys, 1978-79, American Dental Association, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, and Association of Schools and Colleges of Optometry.

Financial Aid Sources from the Health Professions Education Assistance Act of 1976

National Health Service Corps (NHSC) scholarships: recipients receive tuition, educational expenses, and a monthly stipend and are, in turn, obligated to serve in a shortage area for each year of scholarship support; applicants who have second thoughts and fail to accept the scholarship are liable for damages of $1,500. The penalty for failing to fulfill the service obligation is three times the total scholarship assistance plus interest at the maximum prevailing rate, payable in one year. Priority for awards are to be given to first year students and are sex- and color-blind. Awards are made without regard for financial need.

Health Professions Student Loans (HPSL): loan pool is funded at diminished levels through 1980. Loans are limited to students with "exceptional financial need" and limited to an annual maximum adjusted to tuition costs. Interest is raised from 3 to 7 percent.

Scholarships for Exceptional Financial Need (EFN): need-based financial aid with the same beneifts as the NHSC scholarship but without a service obligation, but limited to two first year students at each medical, osteopathic and dental school and one first year student at other health professions schools.

Health Education Assistance Loans (HEAL): new, federally insured bank loans administered by the Office of Education rather than the Bureau of Health Manpower and modeled after the guaranteed student loans. The loans are limited to $10,000 annually and only half of any medical school class may borrow in this program. The interest rate ceiling is 12 percent (plus a 2 percent insurance premium) without subsidies; interest must be paid by the student or accrued while in school. Forgiveness of these loans for service in shortage areas is at the discretion of HEW.

Table 1

Application and Acceptance of Blacks to Medical Schools

Year	Number of Applicants	Number of Acceptances	Percent Accepted
1970-71	1,250	642	51.4
1971-72	1,552	810	52.2
1972-73	2,382	857	36.0
1973-74	2,227	977	44.9
1974-75	2,423	1,000	42.2
1975-76	2,288	931	40.7
1976-77	2,523	966	38.3

Sources: Dube, W.F., Johnson, D.G., "Study of U.S. Medical School Applicants, 1974-75," *J. Med. Educ.* 51: 877-896, 1976.

Gordon, T.L., Johnson, D.G., "Study of U.S. Medical School Applicants, 1975-76," J. Med. Educ. 52: 707-730, 1977.

Gordon, T.L., "Datagram: Applicants for 1976-77 First-Year Medical School Class," *J. Med. Educ.* 52: 780-782, 1977.

Johnson, D.G., Smith, V.C., and Tarnoff, S.L., "Recruitment and Progress of Minority Medical School Entrants, 1970-72," *J. Med. Educ.* 50: 713-755, 1975.

Schildhaus, Sam, *An Exploratory Evaluation . . . of U.S. Medical School Efforts to Achieve Equal Representation of Minority Students.* DHEW Publication No. (HRA) 78-735, December 1977.

Table 2

Affirmative Action and Inaction: Best and Worst Medical Schools

Best Recruitment and Admissions

Under-Represented Minorities (Percent Admitted)*	Women (Percent Admitted)†
1. Meharry Medical College (98.5)	1. Medical College of Pennsylvania (60.8)
2. Howard University (76.6)	2. Univ. Puerto Rico (45.8)
3. College of Medicine of New Jersey (25.5)	3. Univ. Missouri-Kansas City (43.4)
4. Stanford University (22.1)	4. Univ. California-San Francisco (42.1)
5. Univ. California-San Francisco (21.6)	5. Morehouse (41.7)
6. Michigan State University (21.0)	6. Howard University (40.3)
7. Univ. New Mexico (16.4)	7. Michigan State University (36.8)
8. SUNY-Buffalo (16.3)	8. Northeastern Ohio (36.7)
9. Baylor University (16.1)	9. Mount Sinai (36.3)
10. Cornell University (14.9)	10. Northwestern (33.9)
11. Harvard University (14.5)	11. SUNY-Buffalo (33.8)

Worst Recruitment and Admissions

Under-Represented Minorities (Percent Admitted)**	Women (Percent Admitted)††
1. Univ. West Virginia (0)	1. Univ. Utah (9.0)
2. Univ. South Dakota (0)	2. South Alabama (13.0)
3. Albany Medical College (1.9)	3. Univ. Chicago-Pritzker (14.4)
4. Univ. Oregon (1.3)	4. Univ. West Virginia (14.8)
5 Univ. Nebraska (1.6)	5. Texas Tech. (15.0)
6. Univ. Connecticut (1.9)	6. Univ. South Dakota (15.4)
7. Univ. Virginia (1.9)	7. Uniformed Services (15.6)
8. John Hopkins University (2.1)	8. South Florida (16.4)
9. Univ. Nevada (2.1)	9. Univ. Minnesota-Duluth (16.7)
10. Univ. Miami (2.3)	10. Vanderbilt University (16.9)
11. Univ. Tennessee (2.5)	11. Univ. Oregon (18.3)

*Percentage of minorities enrolled in first year class, 1976-77.

†Percentage of women enrolled in first year class, 1978-79.

**Percentage of minorities enrolled averaged over first year classes in 1975-76 and 1976-77 in schools admitting six or fewer minority students during those two years. None of these schools had fifteen or more minorities enrolled in all classes during 1976-77.

††Percentage of women enrolled in first year class, 1976-77.

Sources: Braslow, Judith B., "Current Status of Women in Academic Medicine," paper presented at the Regional Conference on Women in Medicine, New York, March 24, 1979.
Hodge, Juel L., ed., *Minority Student Opportunities in United States Medical Schools, 1978-79.* Washington, D.C.: AAMC, 1977.
Philpot, Wilbertine P., *Minorities & Women in the Health Fields: Applicants, Students and Workers.* DHEW Publication No. (HRA) 79-22, October 1978.

women's representation in medicine. This is significantly below the percentage of women in the population and the 49 percent figure for female enrollment in higher education. As noted above, minority groups have reached a similar ceiling of about 8 percent, also well below their

respective proportion in the population. (The distribution of women and minority enrollments today are summarized in Table 3).

However these seemingly fixed limits are not generally considered quotas. Current ideology holds that the levels in the 1950s that applied to

Recently trends suggested a ceiling for women entering medicine ... The percentage of women entering medical schools actually fell slightly from 1977-78 to 1978-79 for the first time since the early 1950s.

Jews, white ethnics and Blacks were quotas because they were set by the institution. But today, it is said, minority students are underrepresented because of lack of proper qualifications, including lack of education and lack of motivation. While these distinctions are arbitrary, the result is the same as before; low levels of most minority groups in health-professional schools. The distinctions are perpetuated, often unknowingly, by advocates of affirmative action, so that the institutions and the functions which continued discrimination serves are not examined. Exacerbating and underscoring these problems are the financial barriers to health professional school.

(These myths will be examined in greater detail in the second part of this study, "Myths Perpetuating Minority and Women's Underrepresentation in the Health Professions.")

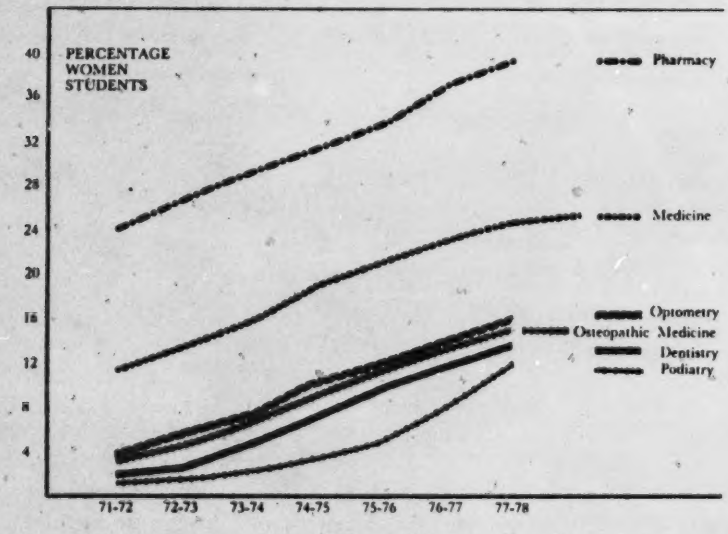
Double Indemnity: Financial Barriers to the Health Professions

Headlines greeted the emergence out of the closet of financial and class barriers to the health professional schools. In 1976 the AMA's own *American Medical News* announced, "Money Becoming Admissions Criterion!" This is nothing new. The unchanging class composition of medical schools over the last sixty years provides clear evidence that class and its correlate, family income, have long been major determinants of admissions (see "Medical Education Since Flexner," *Health PAC Bulletin* No. 76, May/June, 1977).

The financial barriers to the health

Figure 4

Women Students Enrolled in Selected Health Professional Schools



Sources: Johnson, Davis G. and Gordon, Travis L., "Datagram: Medical Student Enrollment, 1974-75 Through 1978-79," *J Med Educ* 54: 431-433, May 1979.
Vetter, Betty M., Babco, Eleanor L., and McIntire, Judith, *Professional Women and Minorities: A Manpower Data Resource Service*. Washington, D.C., Scientific Manpower Commission, November 1978.

professions should be obvious. After completing college, students must be prepared for three or more additional years of study, almost never under conditions which might allow part-time work. The expense of the training itself serves not only as an economic, but a psychological deterrent to low and middle income students. These compound barriers presented by the competition for admission, including sexual and racial stereotypes. But the costs of health professional schools are the final financial barrier to a professional education. Throughout life, persistent obstacles are placed in the paths of many women, most minority and all low-income students who aspire to a professional career.

Despite the New Frontier, the Great Society and the War on Poverty, the percentage of the US population which is impoverished has not substantially changed since 1969—from 12.1 percent in 1969 to 11.8 percent in 1976 (13). But who is affected by poverty *has changed* dramatically. The poverty rate among the elderly dropped 41 percent from 1969 to 1976, while it rose 14 percent for children under eighteen. In 1959 the poverty rate among Blacks was three times that of whites, by 1976 the rate was three and one-half times the white rate. Women have always had less earning power than men in the United States—for example, in 1959 the female poverty rate was two-and-one-half times that of males. By 1975 the rate was four-and-one-half times the male rate. Thus the face of poverty has changed. Today the poor are younger and more likely to be female and Black than in the 1950s.

From the beginning of their educations in primary and secondary schools until their attendance at college, the poor have less of their own personal resources to spend for their education, and less government money is spent on them (14). The property tax structure which finances most primary and secondary education has led

Table 3

Distribution of Women and Minorities in Higher Education and the Health Professional Schools, 1977-78

	Percent of	Percent of Full-Time Enrollment		
Distribution by Race:	**U.S. Population**	**All Higher Education**	**Selected Health Professional Schools***	**Medical Schools**
White	86.6	81.3	88.2	86.6
Black	11.6	9.7	5.0	6.0
Hispanic:				
Mexican-American	3.9	4.3	2.2	1.8
(Chicano)	3.1			1.4
Puerto Rican	0.8			0.4
Native American	0.4	0.6	0.3	0.3
Asian	1.3	1.8	2.7	2.4
Distribution by Gender:				
Men	49.0	51.2	73.0	76.3
Women	51.0	48.8	27.0	23.7

*includes pharmacy, dentistry, optometry, allopathic and osteopathic medicine.

Source: Vetter, Betty M., Babco, Eleanor L., and McIntire, Judith, *Professional Women and Minorities: A Manpower Data Resource Service*. Washington, D.C.: Scientific Manpower Commission, November 1978.

to vast discrepancies in the amount spent on each student, consistently favoring white, suburban, upper-middle class children over poor, minority and urban, blue-collar children. The consequences are twofold: (a) members of the highest socioeconomic classes are disproportionately concentrated in the high "ability" groups among high school graduates, and (b) even among those in the highest "ability" group, fewer poor and minority students enter college, a cumulative consequence of inadequate counseling, support and financial aid, fewer role models, lower teacher expectation and admission bias, real and perceived (15, 16).

Affluence is the important prerequisite for higher education: over the past fifty years a 10 percent increase in family income is associated with a 12 percent increase in college enrollment (17). For example, most of rural Virginia's best Black high school graduates chose not to pursue professional educations because of financial concerns and fears of racism and sexism (18). Among even the highest ability group of high school graduates in Project Talent, an AMA sponsored longitudinal study, only 37 percent of the lowest socioeconomic group enter college, while 82 percent of the highest socioeconomic group enroll. This is a rate lower than those in the two lowest ability groups among the most affluent.

Once enrolled in college a similar double bind faces poor, working class and minority students. In all public institutions of higher education with varying degrees of selectivity, the median family income of their students is directly proportional to the money and resources committed to educate each student—the higher the median income, the more money spent per student (19). Minority students are disproportionately represented in two year and four year colleges which spend the least per full-time pupil; the resources spent by highly selective universities, which have the highest median family income and lowest minority enrollments, is more than three times that spent per student by the institutions which the greatest percentage of minorities attend (19). This discrepancy is present in *public* institutions alone; including private institutions with their greater prestige, selectivity and tuitions and their lower percentage of working class and minority students only make these statistics worse! Among 1974 applicants to medical schools, 66 percent of whites attended schools which had expended more than $2,500 per student, while only 55 percent of Blacks and 40 percent of Chicanos had. Both Black and white applicants from the more affluent schools are accepted at a rate one-third higher than applicants from the less endowed colleges (18).

The disadvantaged also contribute a greater percentage of their family's total income toward their education than do more affluent students. Students whose family income is less than $5,000, while only 8.2 percent of the national undergraduate body, are 10.4 percent of the total relying on personal savings, 13.9 percent of those depending on earnings while taking courses, 17.5 percent of those depending upon their spouses' savings or earnings, 31.1 percent of those using Social Security benefits, and 38.8 percent of those using other sources (mostly extended family contributions) (20).

Once in college the type and amount of financial aid makes a significant difference in whether or not a minority student completes his or her schooling. The size of scholarships or grants is a

major factor in the persistence of Black students. In-college loans and work-study programs seem to enhance Black students' ability to stay in college, especially in predominantly white institutions (21).

The financial aid programs enacted by Congress under the Education Amendments of 1972 are beginning to have a visible impact on the access to and completion of higher education for low-income and minority group students. These aid programs, accounting for $3 billion or 37 percent of the Office of Education's fiscal budget in 1976, include Basic Educational Opportunity Grants (BEOG), Supplemental Educational Opportunity Grants (SEOG), State Student Incentive Grants (SSIG), College Work-Study (CWS), National Direct Student Loans (NDSL) and Guaranteed Student Loans (GSL). All these grants are awaarded on the basis of financial need. While minority students made up 12 percent of all undergraduates in 1974-75, they received 33.6 percent of the total number of grants and National Direct Student Loans. Women made up 42.8 percent of full-time students, but received 51 percent of the total number of awards (although more men than women participate in multiple programs) (22).*

These programs have had an impressive impact. In 1966, for example, 28 percent of all high school seniors who were not planning to attend college gave financial reasons for not attending; by 1975 this figure was down to 8 percent (22a). While the proportion of whites of college age who actually attend college has declined since 1970, the proportion of Blacks and Hispanics has increased (see also Table 12 in Part II). Thus, for the population between ages 16 and 34, Blacks actually had a higher percentage enrolled as of 1976 than whites (23). In 1977 for the $5,000 to $10,000 income range, 17 percent of all Blacks from 18 to 24 years entered college, compared to 15 percent of whites and 11 percent of Hispanics. In the $10,000 to $15,000 income bracket, these figures were 21 percent of Blacks and 17 percent of whites and Hispanics (24).

The grants awarded have—until recently—consistently followed their designed intent: to assist low income students attain access to post-secondary education. Only the private market Guaranteed Student Loans (GSL) provide students whose family incomes are less than $7,000 less support than those whose family incomes are higher. All the other programs—BEOG, SEOG, SSIG, CWS and NDSL—give low income students more aid (22). The success and the consistency of these need-based programs stand in marked contrast to the financial aid record in the health professions.

Federal aid to students is expected to reach $6 billion in 1979-80. But even the success of these programs is in jeopardy. The Middle Income Student Assistance act (MISAA) of 1978 is actually undermining the progressive distribution of aid according to financial need by sharply reducing the expected family contribution toward a middle income student's college education. Since MISAA the Basic Grant (BEOG) may favor middle income students over low income students, as middle income students attending more expensive institutions qualify for more aid than low income students who generally attend less expensive schools (22a). This duplicates a long-established pattern in the health professional schools.

The financial barriers at the final hurdle in reaching medical or dental school despite federal commitments to equal access actually have become *more* formidable in the past decade. A study in 1964 of graduates of predominantly Black colleges demonstrated that 70 percent of the men and 50 percent of the women had wanted to study medicine but could not do so for financial reasons (25). Again in 1977 when Black undergraduates at Texas Southern and Prairie View A&M were asked why they thought there were not more Blacks in medical schools, the reason most frequently cited as crucial was inadequate financial assistance, chosen by 69 percent of the respondents (26). Even those who actually do apply start off behind. Minority students and those whose families earn less than $10,000 consistently apply to fewer schools than do whites and all more affluent applicants (18). More than 15 percent of Blacks (some 400) each year apply only to Howard and Meharry! All limit their chances of being accepted by at least one school. Their im-

*Considerable problems still exist in assessing these programs as records are not kept on all those who apply for financial aid or the dollar amounts which each recipient receives from each and all sources, although data are kept by race/national origin and sex, all the minorities are pooled and no data are available which might discern the awards made to, for example, white men or Black women. Another important limitation for women and minorities is the restriction made upon part-time students, who must attend at least half-time to be eligible.

pressions are an accurate assessment, for even those minority students who do enter medical school are on the average significantly poorer than their peers (Table 4).

"Money is the big problem," Dario Prieto, Director of Minority Affairs at the AAMC, told the *Medical Tribune*. This was echoed by Dr. John Cooper, President of the AAMC. He acknowledged that minority students stopped applying to medical schools when the federal dollars began drying up, tuition and interest rates skyrocketed and scholarships plummeted, while still suggesting that the problem might be in the eye of the beholder. "As a result, the *perception* that minority and other low-income students have of the indebtedness they must incur places medicine beyond their realm of possibilities, *as they view it*" (27) (my emphasis-H.S.). But more than psychological deterrence is at work. More than twice the proportion of minority students than whites were already entering medical schools in debt in 1974, when the declines in new enrollments began. Almost 90 percent anticipated debts before graduation with a mean anticipated debt of $13,300, four times what they entered with—actually an improvement over 1971 (28). Minority students continued to apply, but their acceptance rates fell (Table 1). They were not the recipients of *special interest admissions* (see Box).

Federal withdrawal and reorganization of financial aid support correspond in time with the zenith of affirmative action; its demise followed directly the decline in need-based financial aid—without court order or headlines.

Federal Financial Support for Health Professional Education

With financial problems a major barrier to medical education and with only half-hearted, ineffective support for integration from private groups within the health system such as the AAMC, it is no surprise that minority and women's groups have turned to the federal government for financial and political support. As noted above, federal programs appear to have had a positive impact on minority and female enrollment in other areas of higher education.

But the role of federal support for the health professional schools since 1974, although nominally designed to "increase access of students from all income levels to health professional careers" (12), has actually made access even more difficult. Federal withdrawal and reorganization of financial aid support correspond in time with the zenith of affirmative action; its demise followed directly the decline in need-based financial aid—without court order

Table 4
Percentage Distribution of U.S. Medical Students by Family Income, 1976-77

	All U.S.	White	Black	Hispanic and Native American	Total
Less than $5,000	13	2.9	22.3	15.6	5.0
$5,000 to $9,999	23	8.7	25.2	25.2	10.8
$10,000 to $14,999	24	21.3	23.5	27.4	21.8
$15,000 to $19,999	18	16.7	11.4	11.3	16.1
$20,000 or more	22	50.3	17.6	20.6	46.2

*for 1974 (from U.S. Bureau of the Census)

Sources:

Dube, W.F., "Datagram: Socioeconomic Background of Minority and Other U.S. Medical Students, 1976-77," *J Med Educ* 53: 443-445, May 1978.

U.S. Bureau of the Census, *Money Income and Poverty Status of Families and Persons in the United States: 1974*. Series P-60, No. 99, July 1975.

Special Interest Admissions

On occasion university presidents, deans and other top academics do make "special interest admissions" outside normal admissions procedures and standards. . . . "Benefit" to the school is said to be the controlling factor in such admissions.

The national media in the last two years have carried reports indicating that professional school admissions have, in some cases, been viewed as a means of maintaining good relations with influential or well-to-do individuals who are in a position to assist university appropriations or endowment funds.

Most recently news accounts have focussed on remarks of the president of Boston University during a 1973 school committee meeting. A transcript quotes President John R. Silber as having said:

> We need, for example, a list of admissions considerations that we've given. There have been any number of people crawling all over me for admission to our Medical School and our Law School who have never been tapped systematically for a gift to this university. I'm not ashamed to sell those indulgences. We don't admit someone to our Medical School or our Law School who isn't qualified to get in, but at the same time when we facilitate that admission there's no reason why we shouldn't go right back to the person, the father of the person who's been admitted and talk to him about a major gift to the school. We have not done this systematically.

At the University of California at Davis, the dean of the medical school, in several instances reported in the *Los Angeles Times*, intervened in the admissions process "to correct injustices in the admissions procedures and for public relations reasons."

In October 1975, *New Physician* magazine reported that school records indicated that the Chicago Medical School had in 1973 favored 77 out of 91 qualified applicants on whose behalf pledges of financial support were made to the institution over other applicants otherwise equally qualified.

Most recently, NBC television's "Weekend" program reported on illegal and questionable admissions procedures in the State of Pennsylvania. The US Attorney for the Eastern District of Pennsylvania charged:

> [T]hese schools live and die by what happens in Harrisburg [the State capital] and I think that's why the legislators and the politicians have this kind of hammer over the schools. It is pretty clear, the word on the street is you have to pay off somebody to get into medical school.
>
> * * *
>
> It is extremely pervasive, far more pervasive than we thought when the investigation started.

Legislative pressure on the medical school admissions process in Pennsylvania appears to be a matter of routine, according to one academic official. Dean Joseph DiPalma of Hahnemann Medical College in Philadelphia explained on the same "Weekend" program:

> I would say of all the applications we have, more than half of them will have a letter from a legislator . . . and certainly when any politician recommends a candidate, and does so very strongly, I would be foolish to say that I didn't try to listen and I didn't try to do everything possible that I could. Let's say there's an instance where there's two applicants for admissions, and one of these applicants is favored by a prominent politician, well naturally you'll take the one who's favored since the world works by doing favors. . . .

—*United States Commission on Civil Rights, June 1978.*

credit: **Ken Rosenberg**

or headlines.

Early federal support for health professional education in the US was built into a provision of the Social Security Act of 1935 authorizing grants to states for training and maintaining public health services. In 1952 the President's Commission on the Health Needs of the Nation called attention to shortages in health care personnel and recommended federal aid for the health professional schools, including medicine, dentistry, nursing and public health. Again in 1958 the Surgeon General's Consultant Group on Medical Education reiterated these recommendations. The dramatic launching of Sputnik precipitated the first federal venture into direct student assistance with the National Defense Education Act (1958), which has provided the precedent for all subsequent student aid. After an unsuccessful effort in 1961, the Kennedy Administration re-introduced a bill which proposed a five year student loan program and a ten year construction-grant program for medical, osteopathic, dental, nursing, optometry, podiatry, pharmacy and public health schools. In 1963 the Health Professions Education Assistance Act was passed and signed into law (PL 88-129). The law was amended in 1964 and 1965 to extend the student loan program, encourage expansion through a system of grants based on the number of students in a school (called a "capitation" program), and establish a Health Professions Scholarship program. Allied health professions were included in 1966. (These were the years of major federal activity in health care—Medicare and Medicaid were passed in 1965).

The Health Manpower Act of 1968 (PL 90-490) integrated all of the previous legislation, extended the federal matching for construction, and provided further special project grants designed to increase enrollment and develop new types of health professionals. Many schools reported rising costs and claimed that they were unable to expand without significant additional assistance. From 1964 to 1970 more than $800 million was appropriated under this legislation with 17 percent going to student financial aid.

In 1971 the Comprehensive Health Manpower Training Act extended the loan and scholarship programs with added loan-forgiveness for serving in shortage areas. A major shift took place in the federal approach to institutional needs, moving from "last dollar" distress grants to "first dollar" operating subsidies in the form of significantly larger grants allocated on a per-student basis if schools agreed to expand. The effort to influence specialty choice and geographic distribution and to increase the proportion of minority students was made through special project grants to schools. This included support for regional health centers, family medicine departments and general dentistry training programs and projects designed for "identifying, recruiting and selecting individuals from disadvantaged backgrounds." These programs were to facilitate entry of disadvantaged students, provide counseling and other services to retain them, provide pre-admission programs and publicize sources of financial aid. These newer efforts to affect specialty choice and geographic distribution and to increase minority students were, in effect, voluntary for the schools as they provided the "carrot" of aid without the "stick" of active enforcement of the conditions for the aid written into the law.

Almost immediately after the passage of this Comprehensive Manpower legislation a reexamination of federal health manpower policy began. The doctor shortage was understood more clearly to reflect maldistribution of physicians by medical specialty and geography, which even a substantial increase in traditionally selected and trained health professionals would not relieve. Still language and cultural barriers to health care were not addressed. Nor was the evidence that low income students traditionally choose primary care practices even without incentives or obligation and that

professionals of all racial and ethnic groups largely serve their own communities (29). Nor was the evidence of the ineffectiveness of capitation grants as a means of promoting access examined (30, 31).

In 1973 Congress established the first programs—the Public Health Service and Physician Shortage Area scholarships—to provide financial aid in exchange for an obligation to serve in a shortage area without regard for financial need. A similar Armed Forces scholarship was established under the Department of Defense to meet the military's physician needs. In 1974 a complete phase-out of the Health Professions Scholarships was begun, and support for the loan program began to decline.

After the House-Senate Conference committee could not agree on how to achieve geographic and specialty redistribution during the preceding Congress, a consensus emerged that resulted in the Health Professions Education Assistance Act of 1976 (PL 94-484). As amended in 1977, its major student financial assistance programs include the following:

—National Health Service Corps (NHSC) scholarships—an expanded continuation of service-obligated financial aid awarded without regard for financial need;

—Health Professions Student Loans (HPSL)—continued at diminished levels and limited to students with "exceptional financial need" with interest raised from 3 to 7 percent;

—Scholarship for Exceptional Financial Need (EFN)—need-based financial aid without a service obligation for first year students only; and

—Health Education Assistance Loans (HEAL)—new, federally-insured bank loans at 12 percent (plus a 2 percent insurance premium) without subsidies (see Financial Aid Sources, page 7).

After the Act was signed by President Ford on October 12, 1976, almost two years passed before the publication of the regulations for its student aid programs. Regulations for two of the programs (EFN and HEAL) were published during the summer of 1978, without opportunity for public comment. As a result, for almost three years health professions financial aid was in limbo.

The Impact of Federal Funding and Financial Aid on Affirmative Action

The three stated objectives for federal involvement in health professions education are: (a) increasing the aggregate supply of health professionals, (b) improving the geographic and specialty distribution of these professionals and (c) increasing access of students from all income levels to health professional education. With general expansion of the social services, including the health sector, and fear of a doctor shortage during the late 1960s and early 1970s, academic health centers and the federal government found in these priorities a common self-interest.

The first priority, increasing medical personnel, has been achieved. So much so, in fact, that dramatic expansion of the health professions has now created fears of a doctor *excess*, with its attendant high salary and equipment costs and its impact in driving up medical cost inflation. The second priority, geographic and specialty reallocation, has proved more knotty. Mild constrainsts such as easily met "quotas" for primary care training as a prerequisite for capitation and service-obligated financial aid, as well as new actors within the old medical hierarchy, such as family medicine and mid-level practitioners, have performed cosmetic surgery but have not had much impact on maldistribution of physicians.

Public financing of education in the health professions is often perceived as having two unrelated impacts. On the one hand, society at large is said to benefit from the expansion and redistribution of health manpower. On the other hand, improved access to health careers is seen to benefit only the individual students involved (12). This broken logic blames the victims and exempts the health professions from the common purpose of financial aid in all other areas in higher education—overcoming financial and historical barriers—while obscuring the windfall the affluent white students and communities have received at the expense of poor and minority students and communities. The risk of giving minority and low income students genuine access to the power and prestige of the health professions with the potential challenge they might present to the class- and race-based oligarchy in the schools and in the profession has never been taken.

The goal of direct student financial assistance has been to increase access to the health professions for low income students and, thus, stimulate applications which would then allow the schools to be more selective and improve quality (31). From 1965 to 1973 a total of $295.3 million were allocated for loans and scholarships to the health professions schools for students with "exceptional financial need." Linking

Table 5

Distribution of Medical Students by Family Income Compared to All U.S. Families

	Academic Year: 1963[1]		Academic Year: 1967[1]		Academic Year: 1974[2]	
	Med.	All U.S.	Med.	All U.S.	Med.	All U.S.
Less than $5000	15%	36%	9%	25%	6%	13%
$5,000 to $9,999	36	44	28	41	11	23
$10,000 to $14,999	20	15	22	22	18	24
$15,000 to $19,999	15	4	21	10	15	18
$20,000 to $24,999					13	10
$25,000 or more	14	1	20	2	37	12
Ratio of Median Income of Medical Student Families to All U.S. Families	1.59		1.63		1.58	

Sources: [1]USDHEW *Health Professions Educational Assistance Program: Report to the President and the Congress.* Washington, D.C.: USDHEW, September 1970.
[2]USDHEW, *Survey of How Medical Students Finance Their Education, 1974-75.* Washington, D.C.: DHEW Publication No. (HRA) 76-94, December 1975.

access to increased competition did inflate grade and test scores, but it actually reduced the representation of low income students between 1963 and 1967 (25). (See Table 5.) It proved a windfall for affluent students and for the schools.

Between 1970-71 and 1974-75 successful political pressure for increased minority enrollments dramatically increased funding of the scholarship and loan programs (see Figure 5) and produced a "filter-down" effect of increased aid to minority students, even though inappropriate distribution worsened (see Table 6). For example, in 1971, 40 percent of Blacks, 34 percent of Native Americans, 27 percent of Spanish-surnamed, and 26 percent of Asians received federal scholarships compared to 22 percent for all medical students (32). As a result the proportion of medical students from low income backgrounds increased 25 percent relative to the national family income distribution and the proportion from families with incomes over $25,000 decreased 28 percent during this five year period (12).

The General Accounting Office's report on these programs in 1974 mistakenly concluded that they had not succeeded in attracting students from disadvantaged backgrounds. By polling aid recipients about its impact on their decision to enter medicine or dentistry, the report ignored the dramatic increases in minority enrollments between 1969-70 and 1974-75 (see Figures 1 & 2) and their own conclusions that most students benefitting from the aid programs were not from low income families (33)! After the schools awarded the admissions and aid disproportionately to affluent students, looking for its impact among recipients, not applicants, would certainly assure a negative conclusion. Still, the GAO wisely recommended that the whole aid program be specifically directed to low income students (33).

In the mid-70s the backlash set in. Between the 1973-74 and 1975-76 academic years combined support for affirmative action through the Bureau of Health Manpower—that is, formula and special project grants, as well as student

GAO concluded that most students benefitting from the aid program were not from low income families!

loans and scholarships—decreased almost $103 million!

A study assessing affirmative action efforts for HEW noted a direct correspondence between federal funding and increases in minority enrollment:

> While non-minority enrollment has continued to increase, minority first-year enrollment has followed the same pattern of change as the levels of Bureau of Health Manpower funding except for an apparent one year delay. The sharp increase in BHM support in 1973-74 was reflected in increased minority student enrollment during the 1974-75 academic year. Similarly, the drop in BHM funding to below the Fiscal Year 1973 level appeared to result in a significant drop in the number of nonrepeating first-year minority students enrolled in US medical schools. Thus, the substantial changes in the two most recent Fiscal Years, after a generally increasing trend of funds support, appears to have had major effects on the enrollment levels of minority students in medical education (9).

This change was attributed to costs incurred by the schools of these more expensive students who require more financial aid and are more likely to repeat years or take a decelerated course. Decreasing capitation and financial aid and the increasing costs of inflation made schools even more reluctant to admit low income students. Minority programs, as usual, were on "soft money" and lacked institutional support. The headlines appropriately began reading, "Money Becoming Admissions Criterion" (34).

As funding support waned, so did the very concept of "need-based" financial aid. For twelve years during which these programs largely supported the sons of professionals, no question of "equity" was raised. But when minorities and women first began entering the health professions schools in larger numbers and benefitting, the Republican Administrations conveniently recognized that graduation from these schools virtually assured comfortable incomes and a "high rate of return" on their educational investment (12). Only then did they question the equity of non-service-obligated subsidies. Not only did this new policy deny those historically most likely to serve in shortage areas of "need-based" assistance, it began to concentrate more federal dollars on fewer, more affluent students (Table 7)! Still, Cliff Allen, Director of the Division of Financial Aid at the Bureau of Health Manpower, can say without irony that these changes will have "no effect" on the composition of the health professions' student body and that the priority is putting "a cap on funding." Already during the last two years there have been the first declines in more than fifteen years in the number of applicants to medical and dental schools, primarily due to the loss of lower and lower-middle income applicants (35).

The private sector yields a similar story. The National Medical Fellowships program, founded in 1946 to increase opportunities in medicine for Blacks and expanded in 1970 to include other minorities, has followed the same trajectory as the Health Professions Scholarship and

Table 6

Federal Financial Assistance to Medical Students of Disadvantaged Backgrounds*

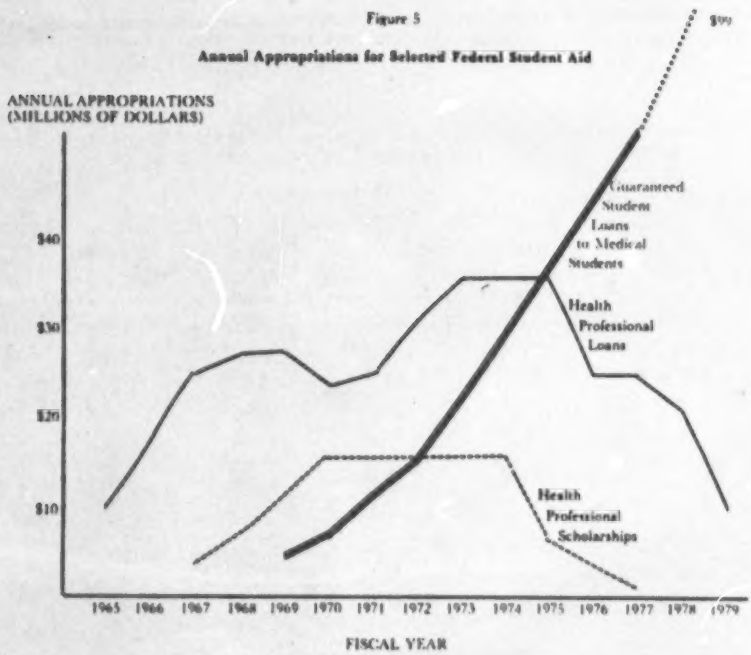
	1971-72		1974-75	
	Number	Percent Assisted	Number	Percent Assisted
Scholarships	6554	60	2048	24
Loans	9835	90	3914	46

*students from families with incomes less than $10,000

Source: Congressional Budget Office, "The Role of Aid to Medical, Osteopathic and Dental Students in a New Health Manpower Education Policy," Washington, D.C.: U.S. Government Printing Office, August 10, 1976.

Figure 5

Annual Appropriations for Selected Federal Student Aid



Sources: General Accounting Office, *Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met*. Washington, D.C.: Government Printing Office, May 24, 1974. Reig, Sonia, Bureau of Health Manpower, DHEW, telephone interview, June 15, 1979. Annual Reports, "Medical Education in the United States," *Journal of the American Medical Association*, 1971 through 1978.

Loan funding. The total number of Blacks and minorities entering medical schools levelled off in 1975-76; the NMF awards peaked in numbers in 1974-75 and in dollars in 1973-74, and continue to decline. In 1978, in order to eliminate a deficit and achieve long-term stability, the NMF scholarships fell below their 1971 number and their 1970 total amount (36). (See Figure 6).

Another major source of private financial aid support ended in 1976-77 when the Robert Wood Johnson Student Aid Program was terminated, although it still maintains some loan funds under the United Student Aid Funds.

The alternatives which remain for low income students who manage to gain admission to the professional schools include the service-obligated scholarships—the NHSC and Armed Forces programs—and the Exceptional Financial Need award, for first year students only. There are the several loan programs administered by the Office of Education (HEAL, GSL, NDSL) and the much diminished Health Professions Student Loan program, as well as limited school and private support. Except for the very wealthy, almost all students will graduate with either service obligations in a shortage area or large accumulated debts of college and professional education. While the former addresses the geographic distribution problem temporarily, scholarships do not guarantee continuous care to underserved areas and commit lengthy and expensive support to both the student and National Health Service Corps (NHSC) practitioner in the field. Those most likely to stay in the shortage areas beyond their obligations, the NHSC volunteers, are now under a hiring freeze. Low income students, both minority and majority, given limited resources will have to accept either a service debt or a significant monetary debt. The latter exacerbates the geographic, specialty and language/culture maldistribution among practitioners, since lucrative specialty practices required to repay huge debts are not to be found in the existing rural and inner city shortage areas.

The Commercial Student Loan Market

As the numbers and size of the loan market grows, it has been privatized, with federal government assuming the financial risks. As can

Table 7

Distribution of Selected Financial Aid Programs for Medical Students by Family Income, 1974-75

	Scholarships				Loans	
Family Income	Health Professional	Public Health Service	Armed Forces	Nat. Med. Fellowship	Guaranteed Student	Health Professional
Less than $10,000	24.2	17.5	17.2	45.2	21.0	27.9
$10,000 to $14,999	37.3	17.5	23.7	29.0	23.5	27.8
$15,000to $19,999	23.6	13.1	22.3	12.9	19.5	18.6
$20,000 to$29,999	10.0	27.5	19.9	9.7	22.9	18.2
More than $30,000	4.8	24.4	16.9	3.2	13.1	7.8
	100%	100%	100%	100%	100%	100%

Source: calculated from Mantovani, Richard E., *Studies of Medical Student Financing: Trends in Medical Student Financing, 1973-74 Through 1975-76*. Washington, D.C.: Association of American Medical Colleges, January 1978.

be seen quite dramatically, while the federal Health Professions Loans and Scholarships are being phased out, the private Guaranteed Student Loans have skyrocketed. In 1970 Guaranteed Student Loans accounted for about one-quarter of all loans to medical students, but by 1977 it accounted for almost 60 percent. The GSL program was initiated in 1965 to subsidize and insure commercial borrowing.

The American Bankers Association (ABA) clearly indicated in a 1975 report that its members were reluctant to make guaranteed loans because of the low interest rates, which were almost two percent below the prevailing market rate. Although the guarantees provide some advantage by eliminating the risk of default, the ABA complained that the various guarantors were slow to refund on defaults (which were increasing rapidly in number), that the Office of Education was inconsistent in pursuing defaultors and that the frequent changes in federal regulations created constant administrative problems. A second survey in 1975 by the Office of Education found that the banks' major objections to the loan programs were their low income and long repayment periods, which during inflationary periods further subsidized the borrower. That study found that without substantial changes in the program, less than 30 percent of the lending banks planned to increase their GSL holdings, and most of these were smaller banks.

To put it simply, the banks told the federal government that without more profit, they would not participate in the program. Congress responded by giving them what they wanted.

To support the banks, the Student Loan Marketing Association (SMLA or "Sallie Mae") had been created in 1972. It is a federally chartered, private corporation which purchases large blocks of student notes from lenders with money borrowed at favorable interest rates from the Federal Financing Bank. The cash which Sallie Mae provides the lender is then reloaned at four percent above its cost or "leveraged" by repeated borrowing from Sallie Mae at 80 percent of the face value of the student loans; multiplying the lender's original capital severalfold resulting in dramatic rates of return—easily as much as 2[illegible] percent on an original $100,000 investment, according to former HEW Secretary Joseph Califano (37)! Sallie Mae, originally designed to attract private capital for student loans, is now 98 percent public capital and deals with only about 100 of the largest of the 8,500 lenders in the GSL program!

This was not enough, as the 1975 ABA report

clearly indicated. To spread the profits around to all its members, the ABA wanted higher interest rates. So, the Tax Reform Act of 1976 was passed, permitting non-profit organizations to purchase the guaranteed loans by issuing tax-exempt bonds. The interest rate of the guaranteed loans was raised to 12 percent—7 percent paid by the student and 5 percent by the federal government. What's more, the recently created Health Education Assistance Loan program surpassed the market with a 12 percent interest rate plus an additional 2 percent insurance premium, for a total allowed interest rate of 14 percent!

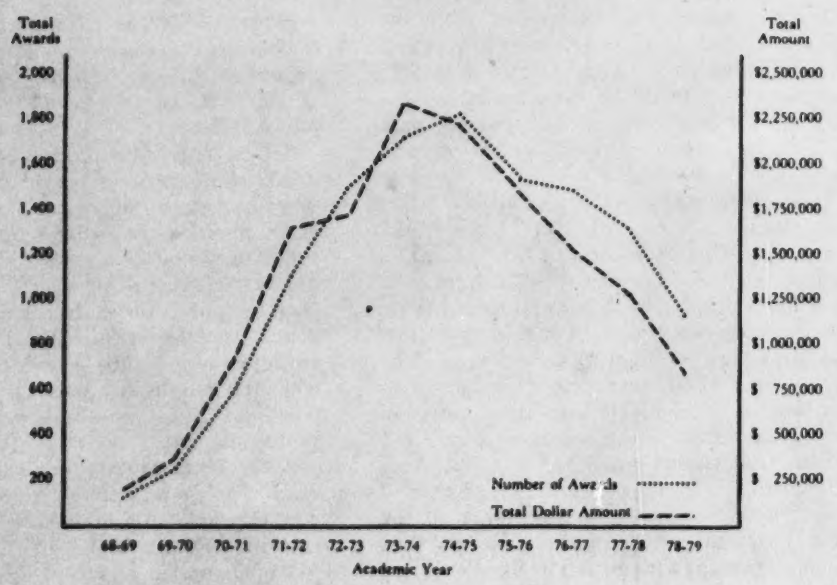
As the commercial interest rates began to soar, former Secretary Califano moved to cut federal contributions to these programs and to cut off loans to Americans studying in foreign medical schools. While the student pays 7 percent interest on a Guaranteed Student Loan, the federal government must pay this to the banks while the student is still in school, as well as the additional 5 percent "allowance" during the life of the loan. The federal government also absorbs the costs of defaults and many collections. Califano's proposed "federal bank" would eliminate the additional costs paid to support the bank's commercial rates. His proposal echoes the AAMC's 1970 recommendations.

Charles W.V. Meares, Chairman of the Board of United Student Aid Funds, Inc., supported by the Robert Wood Johnson Foundation, objected, calling the current subsidy program "a happy combination of Government and private-sector activity" and cited the growing participation of lenders. He challenged Califano's implication that private lenders are reaping considerable profits from student loans, noting that the subsidized interest rate of 12 percent is very near the going market rate (38). If this is true for the Guaranteed Student Loan program at 12 percent, the HEAL's 14 percent rate promises quite a windfall for the private lenders. Both will continue the public subsidy of the largest banks "leveraging" with Sallie Mae.

Medical School Costs

Over the last decade total expenses have risen far more quickly than loans or scholarships, so increasing amounts must be paid from student

Figure 6
Number and Value of National Medical Fellowship Scholarship Awards, 1968-69 to 1978-79



Sources: National Medical Fellowships, Inc., "What is NMF?" New York: National Medical Fellowships, 1979.

Table

SUMMARY OF DISTRIBUTION OF FINANCIAL AID PROGRAMS

Family Income	Percent of All Students	Scholarships: All Scholarships		Scholarships: Public Health Service		Scholarships: School
		Percent	Mean	Percent	Mean	Percent
Less than $5,000	6.0	9.8	$2,625	4.6	$7172	4.5
$5,000 to $9,999	10.0	15.1	3,105	12.7	6,780	17.2
$10,000 to $14,999	18.0	23.4	3,073	17.4	7,721	23.6
$15,000 to $19,999	15.0	17.2	3,190	13.0	6,856	17.6
$20,000 to $24,999	13.0	12.9	2,996	14.1	7,572	14.8
More than $25,000	38.0	21.7	3,413	38.2	8,149	16.3
		100%		100%		100%

Source: calculated from Congressional Budget Office, "The New Health Manpower Education Policy," Washington, D.C.:

and family resources (Figures 7 and 8). At the same time, the number of students who must share these resources have increased, while the Exceptional Financial Need, Armed Forces and National Health Service Corps (NHSC) programs concentrate the total available support among a smaller number of students, only 1.2, 3.6 and 6.6 percent of this year's entering class, respectively.

While federal scholarships were given to 6,554 disadvantaged students in 1971-72 alone, the total NHSC scholarships from 1973-74 to 1977-78 for *all* students, not just the disadvantaged, totalled only 5,715 (39). More and more federal money has been concentrated on fewer students, most of whom are not disadvantaged. The record from 1974-75 (the only year for which such data is available) shows distribution of these funds disproportionately to affluent students (see Tables 7 and 8).

For example, in 1974-75 only 4.6 percent of Public Health Service (the forerunner to the NHSC program) scholarships were awarded to students from families with incomes less than $5,000. The average grant was $7,172, for books, tuition and a monthly stipend. Students from families earning more than $25,000 received 38.2 percent of the available scholarships at an average of $8,149 each, reflecting higher tuitions for many of these students at the nation's most expensive private schools. *The most affluent students on the average received 14 percent more than the poorest students.*

Since the Armed Forces and NHSC scholarships are not awarded according to need, they exacerbate the already class-related financial support systems that actually provide subsidies to the more wealthy, whose tuitions at more expensive private schools are thereby paid from the public purse. In the name of equitably distributing the service obligations, the class inequities continue to be served, just as they were when the non-disadvantaged benefitted from the poor and erratic administration of the Health Professions aid.

A similar maldistribution can be found when examining how disproportionate amounts of NHSC scholarship dollars are concentrated at certain high tuition, private institutions. Although no single school received more than 3.2 percent of the total number of awards, Georgetown University School of Medicine with

8

FOR MEDICAL STUDENTS BY FAMILY INCOME, 1974-75

Administered		All Loans		Loans Health Professional		Guaranteed Student	
Mean	Percent	Mean	Percent	Mean	Percent	Mean	
$1,378	9.2	$2,014	12.0	$1,677	8.8	$1,974	
1,445	14.1	2,193	16.1	1,534	13.9	1,988	
1,280	23.7	1,874	28.9	1,485	23.3	1,982	
1,298	17.8	1,714	19.0	1,450	18.7	2,077	
1,130	13.8	1,394	12.5	1,437	14.7	2,084	
1,064	32.7	912	12.6	1,525	20.6	2,172	
	100%		100%		100%		

Role of Aid to Medical, Osteopathic, and Dental Students in a
U.S. Government Printing Office, August 10, 1976.

the nation's highest tuition ($12,500) received 9.1 percent of the total dollars allocated to allopathic medicine between 1973-74 to 1978-79 (40). The three medical schools in the District of Columbia (Georgetown, George Washington and Howard) are second, third and fourth, respectively, among medical schools in the number of scholarship recipients and receive more scholarship dollars than any of the fifty states (including New York with 12 medical schools), more than 16 percent of the total funds allocated to allopathic medicine. It should be readily noted that the ten schools with the most NHSC recipients are private institutions with high tuitions (see Table 9). Among participating osteopathic and allopathic medical schools, 7.7 percent of these schools, all private, receive 34.5 percent of the total funds distributed. The District of Columbia and nine states receive 72 percent of the total scholarship dollars (see Table 10).

Inequitable distribution of resources impacts adversely on both minority enrollments and the achievement of federal health manpower goals. Evidence from the AAMC longitudinal study of medical school graduates shows that the type of medical school a student attends has a significant impact on the likelihood of choosing an academic career (i.e., a non-primary care practitioner) and the size of community in which the physician is likely to practice (41). Current NHSC scholarship award practices, at least at the institutional level, contradict its goal of supplying underserved communities with primary care practitioners. With the exception

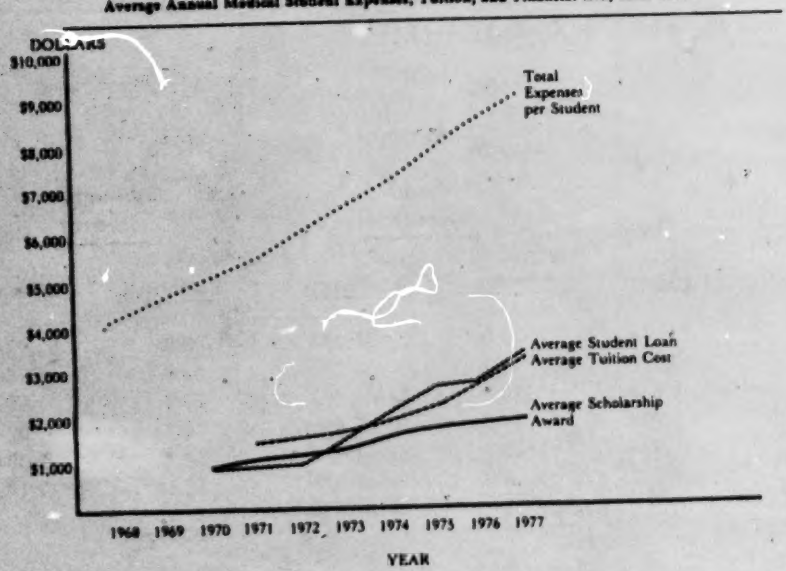
The most affluent students on the average received 14 percent more aid than the poorest students.

of the minority schools, Meharry and Howard, the very institutions most likely to graduate academicians and suburban specialists are receiving the greatest funding.

The NHSC's current selection criteria—work experience, community background and career goals related to underserved areas, traditional faculty recommendations and academic performance—carefully avoid questions of financial

Figure 7

Average Annual Medical Student Expenses, Tuition, and Financial Aid, 1968-1977



Sources: Gordon, Travis L., "Studies of Medical Student Financing, 1977-78," Washington, D.C.: AAMC, D.S.S. Report 78-2, October 1978.
Survey on How Medical Students Finance Their Education, 1974-75. DHEW Publication No. (HRA) 76-94, December 1975.
Annual Reports, "Medical Education in the United States," *Journal of the American Medical Association*, 1971 through 1978.

need, i.e., class (such data are not even collected), race, ethnicity or sex. Since large numbers of scholarships have been awarded to Meharry and Howard students, the overall statistics for scholarship recipients show significant minority and women student representation (see Table 11). Because of the service commitment these figures represent a two-edged sword—minorities and women may be receiving more than their statistical share of scholarships because they have no other choice or because they qualify more readily under the selection criteria.

A more careful examination shows that Meharry and Howard Blacks receive about 45 percent of NHSC scholarships awarded to Blacks, while they represent only about 20 percent of Blacks in all medical schools.* Black Meharry students from families earning less than $10,000 annually are representative of the national aggregate among all Black medical students (46 percent and 47.5 percent, respectively) (42). Whether this is a result of targetting funds to financially troubled Meharry or to Blacks in general through a loophole in an otherwise race-blind selection process remains unclear. But once again the inevitable inequities in the current scholarship distribution are apparent. More than 70 percent of Morehouse's first medical class has NHSC scholarships *and* obligations (17 of 24 students), while about 40 percent of each Meharry class has them (40), both schools risking becoming "indentured" institutions.

Individual abuses of student loan programs exist. A Senate committee is currently investigating the GSL program. Since the family income limitations were lifted in 1978, considerable criticism has been focused on wealthy students who borrow GSL monies at the subsidized rate (see above) and re-invest at the current 13 percent money-market rates while using other funds to pay for their education (43).

Only the private National Medical Fellowship program, aimed specifically at minority students, has consistently followed "need-based" distribution. As a result, it distributes

*The former figure is an estimate based on NHSC scholarship recipients being representative of the Meharry and Howard student bodies and is probably conservative.

most of its money to low income students (Table 7). At the beginning of the AAMC affirmative action program in Academic Year 1971-72, 60 percent of students with family incomes less than $10,000 received federal scholarships and 90 percent loans; by Academic Year 1974-75 when minority admissions peaked, the percentages had declined to 24 and 46 percent, respectively (12). More than half of Black and almost half of Hispanic and Native American medical school students came from these low-income families in 1974-75 (18).

The medical schools blamed Congress for squeezing the disadvantaged. But the medical schools had in fact, since 1963, administered the federal assistance disproportionately to the advantaged, in large part because the disadvantaged were not admitted in the first place. Under the banner of academic freedom they mobilized powerful lobbying efforts through the AAMC that prevented Congress from imposing meaningful quotas for primary care training, for students committed to service in shortage areas and for American transfers from foreign medical schools, and from significantly cutting capitation grants. When it came to major cuts in affirmative action programs and to development of regressive financial aid formulas, somehow, they want the public to believe, they have lost their political clout.

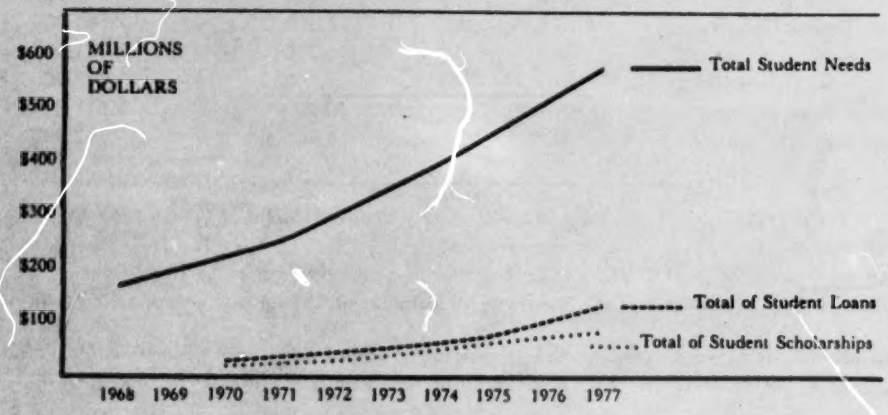
In the absence of strong outside influences, the self-interest of health professional institutions is not served by vigorously defending

Admissions to the health professional schools have largely replicated the existing hierarchy in the society, in the profession and, particularly, in the schools themselves.

progressive, need-based financial aid or need-based admissions (i.e., serving the needs of the nation rather than the profession and the schools). Admissions to the health professional

Figure 8

Total Annual Medical Student Financial Need vs. Total Scholarship and Loan Funds Available, 1968-77



Sources: Gordon, Travis L., "Studies of Medical Student Financing, 1977-78," Washington, D.C.: AAMC, D.S.S. Report 78-2, October 1978.
Survey on How Medical Students Finance Their Education, 1974-75. DHEW Publication No. (HRA) 76-94, December 1975.
Annual Reports, "Medical Education in the United States," *Journal of the American Medical Association,* 1971 through 1978.

schools since Flexner have largely replicated the existing hierarchy in the society, in the profession and, particularly, in the schools themselves. (See Part II of this study.) During the past decades' expansion of the health professional schools' enrollments and funding, additional places and financial aid dollars were given to women and minorities without losing a single white seat and without significant reallocation of resources or places to the disadvantaged (44).

Women and minorities, given sufficient numbers, might bring a set of values and priorities which would challenge the business-as-usual conduct of the academic health centers. They might challenge the way in which "their people" receive care from academic training institutions, the models for the profession, and the manner in which medicine and the other health

The Bakke case has merely diverted attention from the responsibility and complicity of academic institutions in draining the affirmative action movement of its momentum and funding.

professions function as a social control and policing agent upon women, minorities and the

Table 9

Medical and Osteopathic Medical Schools Receiving the Greatest NHSC Scholarship Monies, 1973-74 to 1978-79

School	Number	Tuition	Total Funds
1. Georgetown	273	$12,500*	$4,575,000
2. George Washington	208	11,800	2,798,000
3. Kansas City Osteo.	224	7,000	2,414,000
4. Meharry	298	4,000	2,271,000
5. Loma Linda	193	6,000†	2,249,000
6. Thomas Jefferson	176	7,000	1,680,000
7. Tufts	154	6,200‡	1,479,000
8. Iowa Osteopathic	N.A.	7,500	1,427,000
9. Kirksville Osteo.	N.A.	10,000	1,371,000
10. Boston University	N.A.	6,400	1,242,000

for 1979-80: *now $13,500 †now $10,200 ‡now $9,115

Sources:

American Association of Colleges of Osteopathic Medicine Application Service, "College Information: Entering Class, 1980." Washington, D.C.: American Association of Colleges of Osteopathic Medicine, 1979.

Association of American Medical Colleges, *Medical School Admissions Requirements, 1980-81, United States and Canada*. Washington, D.C.: Association of American Medical Colleges, 1979.

Department of Health, Education, and Welfare, *Training Health Manpower for Underserved Areas, 1973-79: A Report to the People on the National Health Service Corps Scholarship Program*. DHEW Publication No. (HRA) 79-58, 1979.

Department of Health, Education, and Welfare, *National Health Service Corps Scholarship Program: 1978-79 Report to Congress*. DHEW Publication No. (HRA) 79-57, December 31, 1978.

Table 10

STATES RECEIVING THE GREATEST NHSC SCHOLARSHIP MONIES, 1973-74 to 1978-79

States	Total Funds (millions)
1. District of Columbia	$8.6
2. Pennsylvania	8.4
3. Missouri	5.6
4. New York	5.0
5. California	3.8
6. Massachusetts	3.8
7. Illinois	3.3
8. Tennessee	3.0
9. Ohio	1.9
10. Michigan	1.7

Source: Department of Health, Education and Welfare, *National Health Service Corps Scholarship Program: 1978-79 Report to Congress.* DHEW Publication No. (HRA) 79-57, December 31, 1978.

Table 11

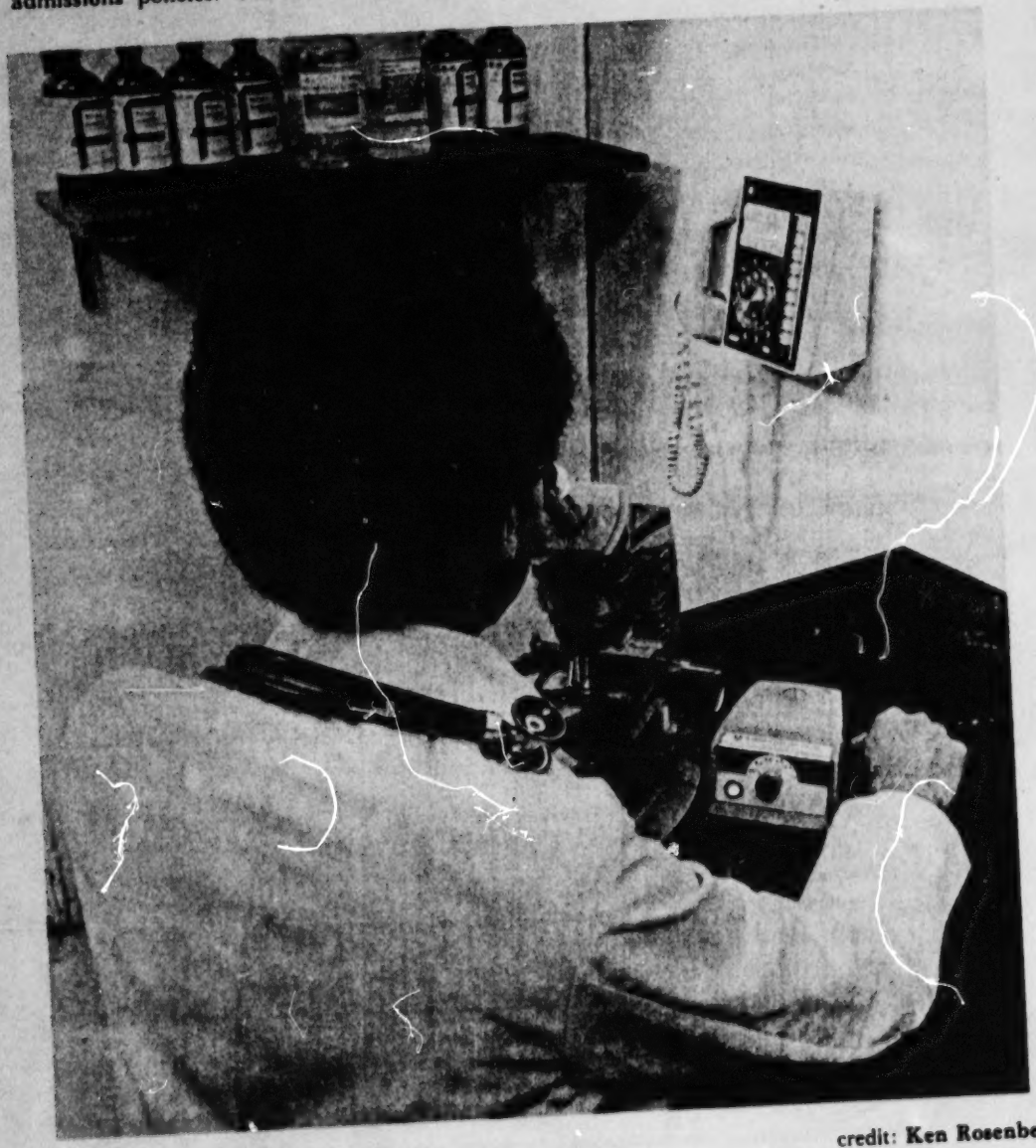
NHSC SCHOLARSHIP AWARDS BY ETHNIC BACKGROUND AND SEX, 1973-74 to 1977-78

	Percentage of NHSC Scholarships Awarded	Percentage of Total Medical School Enrollment
Distribution by Ethnic Background		
Blacks	19.5%	6.0%
Hispanics	3.9	2.7
Native Americans	1.2	0.2
Distribution by Sex		
Women	22.5	20.
Men	77.5	80.

Source: Department of Health, Education, and Welfare, *Training Health Manpower for Underserved Areas, 1973-79: A Report to the People on the National Health Service Corps Scholarship Program.* DHEW Publication No. (HRA) 79-58, 1979.

poor. They might also challenge the ideology which serves the needs of the *status quo* and capital, turning social and political problems like stress, malnutrition and occupational health, into medical ones.

Quite predictably, after the pressure of the civil rights movement waned and fiscal austerity and lowered expectations took its place, the academic health establishment has regressed in its admissions policies. The *Bakke* case has merely diverted attention from the responsibility and complicity of academic institutions in draining the affirmative action movement of its momentum and funding. Meanwhile, investments are secured, federal support curtailed and health professional education returns to business-as-usual. Equal opportunity will remain a mirage as long as opportunites are sold on the marketplace to the highest bidder.



credit: **Ken Rosenberg**

CASE STUDY

COLLEGE OF MEDICINE & DENTISTRY OF NJ: FROM ASHES TO AFFIRMATIVE ACTION

The College of Medicine and Dentistry of New Jersey opened in Newark in the wake of the July 1968 urban revolt. Plans for its opening were among the grievances which moved the people of Newark into the streets during that summer. Those riots and subsequent confrontations have made the school more responsive to the health needs of the inner city where it is located. An organized and involved community participates in the school's decision-making and provides continuing support of a strong minority admissions program, as only one of many commitments secured for the *community's* needs.

The predecessor to the College of Medicine and Dentistry of New Jersey (CMDNJ), the Seton Hall College of Medicine, opened in 1954. By 1955 the medical college had over-taxed the resources of that private university. The state took over the school, located in Jersey City, which became the New Jersey College of Medicine. After two years in Jersey City, interference by local politicians in the affairs of the school prompted the Board of Trustees to look for a new location. Two areas emerged as leading contenders for the new school: Madison and Newark.

In suburban Madison, acquisition of land for the school was easy. Located in an area that relied on New York City and Philadelphia for its referral centers, a medical school in Madison would have given the physicians of this affluent community a convenient place to send patients for specialized care.

With growing pressure to leave Jersey City, the school's clinical programs moved to Newark City Hospital and the East Orange Veterans Administration Hospital before the final decision on the new location could be made. With part of the clinical faculty already there, not to mention its inner city population's excellence as a source of "clinical teaching material," Newark became more attractive. Suburban physicians are frequently unwilling to let medical students and residents "learn" on their private patients. The medically indigent on city hospital wards have little to say about who takes care of them.

The eagerness of city hall finally won the medical school for Newark. Mayor Hugh Addonizio made the school's trustees an offer they could not refuse. Needing about 150 acres for the school, the trustees had found a 138 acre site in Madison. Anticipating difficulty obtaining such a large tract of land in the city, the trustees were ready to reject Newark, when the city played its trump card and offered the trustees a 185 acre site in central Newark, home of the Black and Hispanic communities. Whether the city ever expected to have to deliver all this real estate is now a matter of conjecture. Some city officials claimed that the 185 acres was a ploy to eliminate the trustees' excuse for not coming to Newark and that the largest site the city expected to have to deliver was actually 30 acres. The offer was made and accepted. The Black and Hispanic communities erupted when the bulldozers rolled in to clear the school's site.

For city hall, the medical school meant new jobs, the infusion of federal and state monies and revitalization of Newark's image. For the Black and Hispanic community, the 185 acres meant the destruction of housing and disruption and dislocation of lives. Newark and the Board of Trustees developed the school's plan without consulting the people who would suffer the immediate effects of slum clearance. People, all too familiar and frustrated with past urban renewal projects, took to the streets. Still, the trustees showed no interest in reducing the size of their proposed campus.

The NAACP filed suit to get the plans changed. The Model Cities Act of 1966 mandated that federally sponsored projects have a favorable impact on the communities in which they were located. The NAACP suit contended that unless the trustees' plans changed, the impact would be very unfavorable, since neither the community's housing or health needs had been considered. The trustees responded by modifying the size and shape of the proposed campus to preserve a few more houses.

The community rejected this offer because its health needs were still not addressed—limiting the destruction of the community was not

enough; some positive relationship with the surrounding community needed to become integral to the medical school's plans.

Representatives of the community, the medical school, the city, state and federal governments negotiated through the winter and into spring, 1968. They agreed that the medical school would build its campus on a smaller site—58 acres. The school also made several commitments to health care in Newark. On July 1, 1968, the school took responsibility for medical care at the Newark City Hospital. The school promised to provide medical care at the city facility, and to develop training programs so that community residents could qualify for jobs when the school opened. The school would award construction contracts to minority businesses. These agreements created the Newark Community Health Council to "review and approve programs to be developed and administered by the college to provide community health services to low-income persons in Newark."

Not all the promises were kept. In 1970, community residents confronted the college with grievances about the quality of care at the city hospital and the college's employment practices. Community members threatened to occupy the hospital if changes were not made. Following this confrontation, community members and CMDNJ students, faculty and alumni pressured the Board of Trustees to establish a permanent board to insure community involvement in the affairs of the school. The Board of Concerned Citizens was established. In 1973, CMDNJ bylaws were adopted which mandated input from this advisory group in all college affairs.

The Board of Concerned Citizens (BCC) has made recommendations on the problems of employees at CMDNJ, investigating employee grievances concerning salary, work conditions and career development. This group made recommendations about the care provided at Newark City Hospital and modified plans for the new university hospital to include primary care clinics for local residents in addition to the planned subspecialty units. Because of the BBC's recommendations, the new hospital has an alcohol detoxification unit and a trauma center. At one point the Board of Trustees suggested that instead of building a completely new city hospital, as they had agreed to do in 1968, they build a small referral hospital for the school and modernize the existing city hospital. The BCC helped to block this plan to break earlier promises and prevented the development of a two class (university vs. city) hospital system in Newark.

The BCC monitored the school's commitment to recruit minority medical and dental students. In keeping with the 1968 agreements, minority enrollment has risen from about one percent in 1969-70 to 20 percent in 1976-77 and 17.8 percent in 1978-79.

Trouble developed in 1972 because several minority students had academic problems. When the faculty committee on student affairs met to consider dismissing six students who had failed courses during the first year, community members interrupted the meeting to demand that the students be retained. The BCC mediated the dispute. Four of the students repeated the first year of medical school, and two others were dropped. At the recommenda-

tion of the BCC, the school established special tutorials to help students meet academic requirements and hired a minority student counselor.

As a result, CMDNJ has developed a Students for Medicine program which recruits students and supports them when they have been accepted into the medical training program. College undergraduates take an eight week program which focuses on strengthening their skills in general science. Students who have already been accepted to medical school take courses which will be part of their basic science curriculum—anatomy, physiology and biochemistry. All the students attend seminars to improve their studying skills. Selection for this program is not a guarantee of medical school admission but more than half of the programs undergraduate participants do enter medical school, in New Jersey or elsewhere.

From the riots of 1968 to the Board of Concerned Citizens now, the people of Newark have influenced the policies of the medical school. The original commitment to respond to the health needs of the community prompted by the riots in 1968 is being monitored by a board with official standing in the school's bylaws. One way that the school shows its commitment to the health of the surrounding community is by training physicians who will stay in Newark. Despite Bakke, cutbacks in financial aid and a national trend away from affirmative action, CMDNJ continues to have one of the best minority admissions records in the nation. This record should continue as long as the community supports affirmative action and insists that the medical school fulfill its commitments to Newark's health.

—Richard Younge

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credit: **Martin Luther King, Jr. Health Center, Bronx, N.Y.** 31

CASE STUDY

THE SOPHIE DAVIS CENTER FOR BIO-MEDICAL EDUCATION: IDEALS BECOME ORDEALS

In 1973 the Sophie Davis Center for Bio-Medical Education (Bio-Med Program) was opened at City College of New York (CCNY). From the beginning, affirmative action was one of the program's goals, but not its only one. After two years of successful affirmative action, the program joined the national trend of declining minority admissions.

Two very different interest groups supported the Bio-Med program. In 1969 the City University of New York began a policy of "open admissions" admitting any New York City high school graduate. Some of the CCNY science faculty complained that since "open admissions" the quality of students had declined. The science faculty wanted to attract the "good students" back to CCNY. A medical school might do the trick.

Black and Hispanic community and student organizations wanted to promote the training of physicians for their communities. One way to attain this goal was to increase the number of minority medical students, particularly Blacks and Hispanics from the city's public schools. Robert Marshak, president of CCNY at this time, stated, "Keeping in mind their representation in the college and in New York City generally, we want to get substantial numbers of minority students" (*New York Times*, June 6, 1973).

The Bio-Med program was structured differently from traditional medical programs. The Bio-Med program would lead to a MD degree six years after high school—instead of the usual four years of college followed by four years of medical school. Students admitted to the program would spend four years at CCNY and then transfer into one of eight medical schools for the final two years of clinical training leading to the MD degree.

The science faculty now had an academically rigorous training program to attract the type of students they felt would save the college from its supposed academic decline. Those who wanted to train more minority physicians saw different advantages. This program trained doctors two years faster than a traditional program. Also instead of the usual two hurdles to medical education—college and medical school admissions—a student admitted to the Bio-Med program was guaranteed a spot in one of the affiliated medical schools.

The Bio-Med program also required courses in medical sociology and politics, community organizing and epidemiology, and field experience in community agencies to help maintain and develop the students' commitment toward urban primary care.

In September 1973 the first class admitted was, in fact, representative of the racial mix of the city's high schools. Fourteen Hispanics, ten Blacks, and nine Asians were in the original class of 62. Half of the class were women. At this time Blacks and Hispanics made up one third of the New York City population and more than half of the city's high school population.

By the time that class had completed its first year, controversy surrounded the program. In May 1974, Harry Lustig, Dean of Liberal Arts at CCNY, charged that the Bio-Med program was pressured into the use of racial quotas by community groups from Harlem—the neighborhood where CCNY is located. The oft-used charge that underqualified minority students were taking the places of better qualified students was trotted out for another go-around. B'nai B'rith began to investigate a charge of reverse discrimination brought by the father of two white students with good academic records who were not admitted.

Proponents of affirmative action insisted that the racial composition of the first class was attained while adhering to the selection criteria of academic performance plus social commitment. A New York City Human Rights Commission investigation, reported in the *New York Times* on June 8, 1974, said that "recruitment was based on commitment to serve as a physician in an urban area and represented a concern for scholastic achievement, geographical location, community sensitivity and concern, all of which are vital ingredients for bio-medical pursuits."

Despite controversy over reverse discrimination, the Bio-Med program admitted 22

Blacks, 14 Hispanics, and 5 Asians to its second class of 68 students.

During the first two years of the program's operation, a number of minority students ran into academic trouble. Inner-city New York schools did not offer decent preparation in science. Students, no matter how talented or motivated, could not be expected to survive an accelerated medical program without extra academic help.

Students complained that the program brought them in but did not make a good faith effort to keep them there. The tutorial and remedial help made necessary by poor quality public schools was unavailable. Minority students were subjected to the humility of accusations that they were not qualified to be in the program.

The *New York Post* ran a series of articles "exposing" students who were given a second chance on some exams. Although make-up exams are common practice at many medical schools, the CCNY administration began to give in to the pressure. Instead of starting programs to help students with less extensive preparation, it talked about criteria for academic probation and dismissal. In Fall 1977, only 35 of the original 62 students completed the required courses at CCNY and were ready to continue to the final two years of training.

In 1975 a new admission procedure began, weighted more in favor of academic preparation. Scores in science and mathematics regents exams received more careful consideration. This eliminated many minority students from the picture, because many predominantly Black and Hispanic high schools do not even offer the courses needed to prepare for the regents exams.

The Bio-Med classes of 1975-1978 slid back toward the national average number of minority students. Increasingly, students came from suburban and middle-class backgrounds.

The commitment to bring the "good students" back to CCNY took priority over the need to change the complexion of medical school classes. As the number of minority students from the inner-city fell, so did the level of students' interest in primary care and community health. The instructors of the community health courses had a hard time interesting suburban students in urban community health.

Anti-affirmative action forces in the program received legal blessing in August 1976. Despite the fact that affirmative action was on its way to being discarded, B'nai B'rith and the Italian American Center for Urban Affairs filed a Bakke-like suit to guarantee that affirmative action would not be practiced at the Bio-Med program. On August 18, 1976, federal Judge Marvin Frankel found that "19 whites and Asians had been intentionally eliminated on the basis of race from the list of students selected in 1974."

The selection process which resulted in a high proportion of minority students was not the main issue of the suit. If the Bio-Med program selected students based on criteria giving social commitment and academic performance equal weight, as it did during the first two years of the program, the court's ruling might not have been made. The court found fault with the process used to fill places of students who were invited to attend the program but decided not to. Race could not be the sole criteria for calling people off the waiting list, because this implied the existence of so-called "Black slots" and "Hispanic slots."

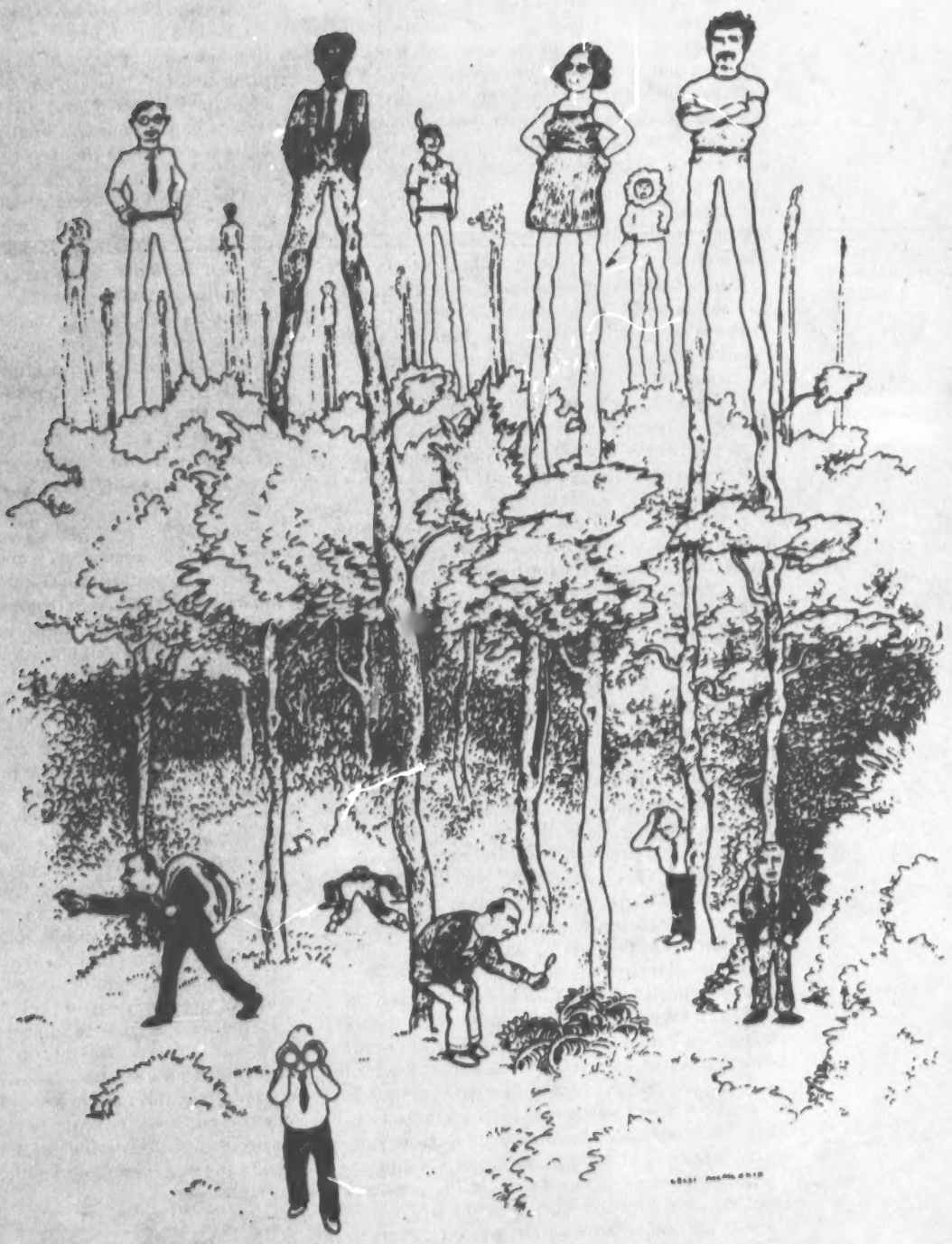
Since 1975 the CC[illegible] science faculty who see the Bio-Med program as a method to up-grade academic standards at CCNY have had the upper hand. This year the advocates of urban community medicine have made some gains. The Fall 1979 entering class has about 18 percent Blacks and Hispanics and 11 percent Asians. According to Jack Geiger, professor of community medicine at the program, several factors contributed to this advance.

A new program called the Bridge to Medicine provides science education for selected high school students. If the science classes they need are not available at their schools, they take the required courses at City College. Several of the incoming students were in this program.

Programs are starting to recruit Bio-Med students from the families of the members of New York City labor unions. An option for students to go through in seven or eight years instead of the very intense six is being developed.

Whether the Bio-Med program can continue to admit minority students at an increasing rate and provide the support necessary to keep these students remains to be seen. In a period of a downward trend in minority medical school admissions and decreasing support for affirmative action in employment and education, it will be a struggle.

—Richard Younge



PART II
MYTHS PERPETUATING MINORITY AND WOMEN'S UNDER-REPRESENTATION IN THE HEALTH PROFESSIONS

The cumulative effects of inflation, changes in federal financial support and institutionalized racism have hurt affirmative action programs in health professional schools and reduced the percentage of minority students entering these schools to that of ten years ago. In their wake, rationalizations have developed to make this failure palatable to majority and, to some extent, to minority groups.

Besides the attributions laid to the "chilling" impact of the *Bakke* and *DeFunis* legal decisions, which locate the responsibility for their failure to meet their own affirmative action goals beyond the control of the academic health establishment, there are numerous myths, usually based on some modicum of fact or unexplained stereotypes, that quite simply blame the victims of discrimination for their plight and hold them entirely responsibile for changing their situation. These myths serve an ideological function, narrowing the terms of the debate and the field of alternatives. These myths are insidious, they have been adopted at times by even such proponents of affirmative action as the Student National Medical Association, the editorial writers of the *New England Journal of Medicine* and the guardians of liberal academic interests, the American Association of Medical Colleges (AAMC).

The danger of such ideology is that it legitimizes the dominant interests which are served by a system which dismisses affirmative action as only serving the interests of those individuals who directly benefit from it. Describing affirmative action as an individual solution rather than a social program promotes the "reverse discrimination" charges by pitting individuals against each other for scarce seats in health professional schools. Instead, the broader community and social benefits of affirmative action must be examined. Federal health manpower policy aimed at meeting the unmet needs of underserved communities, rural and urban, white and minority, will be best served by vigorous affirmative action. Affirmative action is only one consequence of demanding that public funding support of health professional schools begin to meet national, rather than professional, needs.

The ideology—and the system it supports—makes the possibility of alternatives unthinkable, curious heresies or irrelevent eccentricities (45). It results, too, in a patchwork of narrow solutions, aimed at mythical problems, that quite predictably fail to accomplish their goals, yet relieve the participating institutions of their public obligations, atone for liberal guilt and leave untouched and unquestioned the structural inequities which have created and perpetuated racial and sexual discrimination in the health professions since Flexner.

"Blacks and other minorities have lower aspirations and less motiviation."

The old racist stereotype of the lazy, shiftless Black has been reincarnated, in psychological jargon, as rationalization for the limited progress made in the drive for minority parity. In an aritcle published in the prestigious *New England Journal of Medicine*, nominal advocates of affirmative action cited the low degree expectations of Blacks as a hurdle to parity in medical schools (46). This is supported by the observation that the combined percentage of Black students aspiring to become physicians, osteopaths, dentists and veterinarians is less than for whites. Yet *in every year examined*, the study referred to by the authors found a greater percentage of Black freshmen aspiring to the MD or DDS degrees than white freshmen (47; also, 9). In fact, Blacks have higher degree aspirations than non-Blacks in *all other* advanced degrees identified—Masters, PhD, EdD, LlD, and JD (47). These higher aspirations persist well beyond the freshman year of college.

On self-ratings of students aspiring to health careers of all types, Blacks and Native Americans ranked highest in their drive to achieve, greater than whites, Asian- and Hispanic-Americans (48). In the same study Black and Hispanic students evinced greater concern with achievement in their chosen fields than non-minorities. These high expectations

were matched by realistic assessments of the relative financial and academic disadvantage of minority students (48).

A 1978 survey of more than 2,500 Black undergraduates at 19 southern colleges and universities found that 41 percent had a master's degree as their ultimate educational objective, 18 percent an academic doctorate and 12 percent a professional degree (49). Only one quarter aimed only toward a baccalaureate degree and 3 percent toward an associate degree. These aspirations are higher than those of Blacks (from a national sample of freshmen) in 1971, whose aspirations even then were higher than whites as a group (47).

Black medical students anticipate longer training periods than their white counterparts. For all medical students surveyed in 1974-75 the mean number of years of residency anticipated was directly proportional to the student's socioeconomic background—the greater the family income, the greater the number of years of residency anticipated—*except* for Black medical students who planned upon more years of training than any other racial or ethnic group (28).

Still the myth persists. When the best Black high school graduates cited financial concerns and fears of racism and sexism as reasons for not pursuing professional educations, the *AAMC Education News* blindly observed, "Considering that these were the best students, this again illustrates the very limited educational aspirations of the rural Black high school senior" (18). Lower aspirations and motivation are an old fiction, revived for a new racism.

"Blacks have greater academic attrition from colleges and from careers in the health fields."

In the article mentioned above, a deeply ingrained belief was passed as fact: the authors claimed that Blacks drop out of college and from health career majors at a greater rate than non-Blacks (46). If junior college students are excluded, this is simply not true. The author of the source cited to support their argument, in fact, found that when considering only four year colleges and universities, "Black students at such institutions were, in actuality, somewhat less likely to drop out than were non-Blacks whose abilities and past achievement were comparable" (50).

Evidence has accumulated for all students that college attrition is more closely related to aspects of social integration than academic factors, especially informal contact with faculty (51), a sensitive issue for minority students on white campuses (49). The most common reason for dropping out has been "boredom with classes" (52). Black students leave college for financial reasons and marriage more often than white students (19). Persistence for Blacks is particularly enhanced when they can earn credit by examination for skills and knowledge acquired outside traditional classes (52). Colleges using non-traditional testing methods increased retention of twice the number of Black students as whites (53). The form and amount of financial support plays an important role in all students' success in completing college, especially Blacks (21; see also Part I). Attrition among Blacks appears neither higher nor necessarily academic, as the myth would have us believe.

In fact, Black freshmen choosing health fields (not just pre-medical) were *more* likely to remain in these fields but less likely to be recruited to them from another field after graduation than non-Blacks (54). A greater percentage of Blacks and Native Americans received baccalaureate degrees in the health professions than non-minorities (23). Were the health sector not such a caste system, if it allowed some vertical mobility between levels without expensive and full-time retraining and with credit for experience, considerably more minority men and women might rise to the top the hard way.

In addition, between 1966-67 and 1974-75, interest in health careers among minorities increased 106 percent, almost twice the increase among white students. One-and-a-half times more Native Americans and twice as many Blacks and Asian-Americans showed interest in health careers during this time, so that the latter two groups were actually over-represented among health career aspirants (48). Most striking of all were the increases in minority students aspiring to nursing and medicine (200 percent and 136 percent, respectively) compared to whites (110 and 14 percent, respectively). Thus the growth in interest among minority students in medicine was almost ten times that of whites, in nursing almost twice that of whites! This trend continues today (49).

To prepare for these careers, among Blacks there was a 110 percent increase in premedical majors between 1966-67 and 1972-73, a 233 percent increase in therapy majors, a 218 percent increase in bio-physics and a 168 percent increase in biology majors. The problem does not seem to be related to attrition or lack of sustained interest in health careers.

Table 12
High School Graduation and College Participation by Race in the United States, 1950-1977

Year	Percentage of High School Graduates in the 20 to 24 Year Old Population		Percentage of High School Graduates with One or More Years of College		Percentage of Population Age 20 to 24 Years with One or More Years of College	
	Black	White	Black	White	Black	White
1950	25%	56%	32%	35%	8%	20%
1960	42	67	29	38	12	25
1970	62	81	31	49	19	39
1977	75	85	42	48	32	41

Source: Mingle, James R., *Black Enrollment in Higher Education: Trends in the Nation and the South*. Atlanta: Southern Regional Education Board, 1978.

"Recruitment of minorities to medicine and the health professions should begin in high school and earlier."

The early decision by Black medical graduates to study medicine (55) and the relatively small percentage of Black and minority high school graduates who go on to college, compared to whites, has been used to divert attention on minority recruitment as far away from academic health institutions as possible. (9). This recommendation was first made in the 1940s (5)! A *New England Journal of Medicine* editorial moved the focus even further, suggesting that recruitment begin in Projects Head Start and Follow Through!

However, once again the evidence suggests time has made this cliche an anachronism. Data from the Bureau of the Census, assembled in Table 12, shows that Blacks have almost caught up with whites in graduation from high school and entrance into college. Since 1950 there has been a steady increase in the percentage of Black high school graduates in the population, while the percentage of Black high school graduates entering college actually declined from 1950 to 1970. From 1970 to 1977 the percentage of Blacks completing at least one year of college has increased 68 percent while the comparable figure among whites has remained virtually unchanged (see Table 12).

An effort to recruit and follow students from high school, conducted by the AMA itself, disproves this as a primary approach to affirmative action. Project Talent surveyed 11,507 high school graduates. The AMA then followed their progress toward medical school. Those who chose medicine as a career in high school and were ultimately enrolled in medical school represented the highest socioeconomic group; the next highest socioeconomic group was those who chose medicine but failed admission. The middle group chose other fields in high school but was ultimately enrolled in medical school. The lowest socioeconomic group was those choosing medicine but never applying (56). Again in 1974-75, it was found that the best and the brightest Black high school graduates in rural Virginia did not seek professional educations because of financial, racial and sexual barriers (18).

In view of this pattern, generating more high school interest among the disadvantaged without lowering socioeconomic barriers would appear only to generate more failure and frustration. A comprehensive program which includes financial aid, special counseling, and the acknowledgement of minority or disadvantaged backgrounds in admissions, such as the Med Start program in Arizona, on the other hand, has demonstrated retention beyond expectations and successful entrance into a variety of health training programs (57).

Later, not early, recruitment appears more fruitful, given the relative lack of recruitment during college to the health professions among minorities. This may be particularly true of the less highly visible health professions—osteopathic medicine, optometry, dentistry, podiatry and pharmacy. Traditional access, as indicated in the socioeconomic differences among health professions students presented in Table 13, means that professions

Table 13

Percentage Distribution of Selected U.S. Health Professional Students by Family Income, 1970-71

	Medicine	Osteopathic Medicine	Dentistry	Pharmacy	Podiatry	Optometry
Less than $5,000	6.8	12.4	7.3	16.9	11.3	9.8
$5,000 to $9,999	20.1	25.2	22.0	31.6	24.8	26.0
$10,000 to $14,999	24.9	27.9	29.8	28.7	27.7	28.8
$15,000 to $19,999	14.8	13.5	15.7	12.7	15.3	13.7
$20,000 to $24,999	11.5	7.2	11.0	5.3	10.1	9.6
$25,000 or more	21.8	13.9	14.3	4.7	10.8	12.2

Source: Barbano, J., *Minorities and Women in the Health Fields: Applicants, Students, and Workers*, Washington, D.C.: DHEW Publication No. (HRA)75-22, May 1974.

other than medicine and dentistry reflect the class backgrounds of minority students more congruently (see Table 4), and, therefore, these professions need primarily overcome only racial (as opposed to economic) barriers to achieve equal representation. Some professions have shown an increasing interest in minority recruitment at this level (58). College-level recruitment still has untested potential.

The vast majority of Black college graduates pursuing advanced degrees still choose education, five times the number choosing health professions (61 percent of all doctorates earned by Blacks in 1975-76). Once the only available field for Blacks, education offers the same mixture of cultural opportunity and coercion that nursing or pediatrics has offered to women. The comparable opportunities for service and security in the health professions might attract many capable candidates. This pattern is changing, as the market for graduates in education, social science and home economics, traditionally favored by Blacks, has become saturated (59). Blacks have shown increasing interest in health careers, reflecting these conditions (see above).

More recent Black medical graduates have chosen medicine later in or after college, than graduates before 1970 (55). Those responsible for federal health manpower priorities should encourage the trend—those choosing primary care as their specialty are among the latest to choose medicine as a career (41; 60).

"The pool of college undergraduates and minority applicants is not large enough to achieve representative minority enrollment in the health professions."

The growth of the percentage of Blacks and minorities among college students has continued through this decade (see Table 12). A greater proportion of Blacks between 16 and 34 years now enter college than whites (23); a greater percentage of college-aged Blacks from the $5,000 to $15,000 income bracket entered as freshmen in 1977 than whites in the same income bracket (24). Blacks represented 5.2 percent of university, 11 percent of four-year college, and 13.1 percent of junior college students; Hispanic students made up 2.7, 3.9 and 7.1 percent of these enrollments, respectively (23). Many attend traditionally Black colleges, which still award almost half of all Black baccalaureate degrees (23). About 80 percent of all Black physicians and virtually all Black dentists are graduates of these institutions. Black college graduates have earned almost 75 percent of all the Black PhDs in the natural sciences, almost all acquired at white universities; even in the progressive 1960s a higher percentage of Black PhDs came from Black colleges than during the previous decades (61).

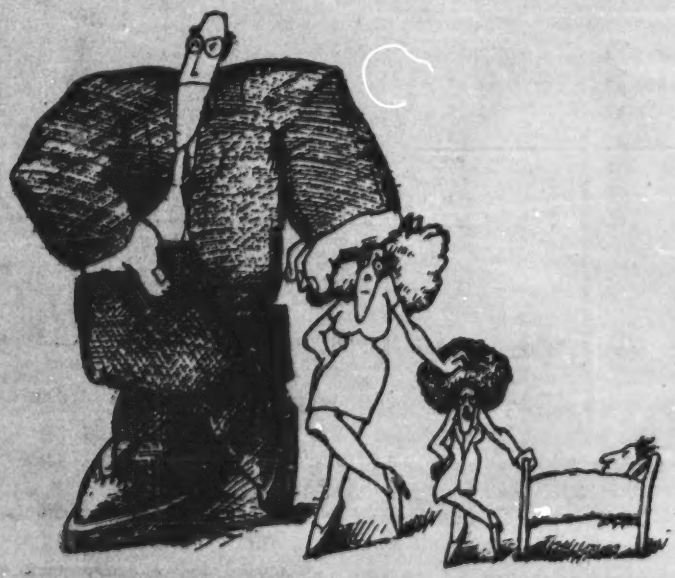
With this impressive record in the face of open and sanctioned discrimination, the potential of Black colleges when these barriers are supposed-

ly lowered would seem to be unlimited. However, predominantly white medical schools have accepted a decreasing percentage of their applicants from the Black colleges since 1970 (10). The professional schools presume that Black students from predominantly white institutions are better prepared for and adjusted to the white medical school environment (read: have learned their place) (10). Howard and Meharry do not participate in this institutional racism and enroll a higher percentage of their applicants from the Black colleges (10). With this degree of institutional racism evident, discounting a huge pool of potential candidates, it is not surprising that almost 18 percent of all Black applicants only apply to Howard and/or Meharry (10).

A recent survey made such institutional racism more explicit (62). Before Dr. John Cooper of the AAMC intervened to preserve academic medicine's liberal reputation, 44 deans and associate deans answered a survey circulated by the editors of *Private Practice*, the official journal of the American Association of County Medical Societies. The survey asked the deans to list the ten best and ten worst medical schools. The best were predictable—John Hopkins, Harvard, Duke and Yale, but even the editors were embarrassed by their other results. The deans chose Howard, Meharry and the University of Puerto Rico—the predominantly minority schools—as the nation's worst. The opinion of the academic medical establishment is clear in its readiness to institutionalize and simultaneously condemn a separate but not equal, victim-blaming process. Little wonder that they are not interested in the graduates of Black colleges.

A summary of the fate of the Black applicant pool from 1970 to 1977 shows the expanding pool of physician aspirants and increasing interest in medicine among Black students enrolled in colleges and universities, presented in Table 14. The aspirant pool more than doubled between 1969 and 1973 (the potential applicants for 1973 to 1977). Meanwhile, the portion of aspirants who actually apply and the percentage who actually are accepted has declined, the fall in the applications realized from physician aspirants beginning the year after the dramatic drop in the acceptance rate in 1972-73. The percentage of aspirants who apply is now 27 percent lower than in 1970, suggesting that less opportunity is perceived now than ten years ago.

The percentage of women and minorities accepted directly affects the number who apply; at one school where 22 percent of those admitted were women from a pool of 12 percent, the following year had a 98 percent increase in female and only a 15 percent increase in male applicants (63). The number of Black applicants has stayed about the same since 1972-73, the year when the acceptance rate was lowest (Table 14). While some see this as the consequence of the backlog of older applicants being dried up, by 1974 the median age of Black and white students accepted to medical schools was almost identical (23.6 and 23.3 years, respec-



tively) (18). Most of the loss of applicants realized from aspirants has occured since then. The barriers to medicine are again returning. Increasing numbers of potential applicants are being discouraged and lost during their college years, so that the gains minorities have made in the undergraduate schools are being limited by the professional schools. The causes are political and economic, not the depletion of a mythological "backlog of qualified candidates," or applicant pool. Clearly, these aspirations are being turned off.

"To admit more minority students, health professional schools will have to lower their admission standards."

The heart of the controversy in the *Bakke* case was the separate processes employed at UC-Davis for regular and disadvantaged applicants. An AAMC study demonstrated that racial status had greater impact than economic status upon the traditional selection factors of grade-point averages (GPA) and medical college admissions tests (MCAT) (64). The generally lower GPAs and MCAT scores for minority students and their high repetition rates of academic courses are cited as evidence that "unqualified" applicants are being admitted.

This argument neglects the long controversy surrounding the MCATs' ability to predict any *outcome* of medical training except performance during the first year. Personality traits, particularly in combination with "academic" variables, have proven to be the most powerful predictors of not only medical school grades, but also scores on the National Board of Medical Examiners tests (65) and overall medical school performance (66). Most recently, moral reasoning has been shown a predictor of clinical performance (67). Much evidence has accumulated

Table 14

Potential Black Applicant Pool vs. Actual Application and Acceptance to Medical Schools, 1970-71 to 1977-78

	College Freshmen			Applicants		Acceptances	
Year	Total	Physician Aspirants	Percent	Number	Percent of Aspirants	Number	Percent of Applicants
1970-71	58,156	2,983	5.1	1,250	41.9	642	51.4
1971-72	58,475	2,626	4.5	1,552	59.1	810	52.2
1972-73	85,430	3,374	4.0	2,382	70.6	857	36.0
1973-74	98,270	3,567	3.6	2,227	62.4	977	44.9
1974-75	98,657	4,114	4.2	2,423	58.9	1,000	42.2
1975-76	97,684	4,591	4.7	2,288	49.8	931	40.7
1976-77	135,504	7,968	5.9	2,523	31.7	966	38.3
1977-78	128,619	8,103	6.3	2,482	30.6	959*	38.6

*actual new first year students

Sources:

Dube, W.F., Johnson, D.G., "Study of U.S. Medical School Applicants, 1974-1975," *J Med Educ* 51: 877-896, 1976.

Gordon, T.L., Johnson, D.G., "Study of U.S. Medical School Applicants, 1975-76," *J Med Educ* 52: 707-730, 1977.

Gordon, T.L., "Datagram: Applicants for 1976-77 First Year Medical School Class," *J Med Educ* 52: 780-782, 1977.

Johnson, D.G., Smith, V.C., and Tarnoff, S.L., "Recruitment and Progress of Minority Medical School Entrants, 1970-1972," *J Med Educ* 50: 713-755, 1975.

Schildhaus, Sam, *An Exploratory Evaluation. . .of U.S. Medical Schools' Efforts to Achieve Equal Representation of Minority Students*, Washington, D.C.: DHEW Publication No. (HRA) 78-735, December 1977.

which shows that standardized test scores cannot be employed accurately to predict performances between Blacks and whites or applied in the same manner *among* groups of Black or white students (68). Work at the Cultural Study Center at the University of Maryland has shown that the constellation of positive self-concept, realistic self-appraisal, long range goals, leadership experience, community service and preparation for racism to be a measurable and useful predictor of success for minority students (68).

The GPAs and MCATs of minority students are currently at the same level as that of *all* admitted students in the early 1960s and their retention and progress in medical school is comparable to *all* students during those years (69). Minority students, frequently starting behind other students, have shown that they can and do catch up by the end of their medical education (18). Many of these non-academic traits and those found to correlate best with superior performance in medical school are those which minority students aspiring to health careers identify more than majority students in self-descriptions (48, 70).

Several studies have found that lower class students have had to have higher grades to gain entrance to medical school (71, 72). Acceptance rates to medical schools increase directly with family income, even though some of the middle income groups have the highest GPAs and MCATs (73). The median family income of those accepted was $2,300 more than that of those who were not (73). No class action suit has ever been brought against applicants whose families earn more than $50,000 who are admitted at a higher rate than any other group, yet have lower GPAs and MCATs than many other income groups! Income skewing has been going on since Flexner, seventy years ago (74).

It is now well established that the likelihood of an individual pursuing a primary care practice is *inversely* related to family income (75), so that admissions policies which perpetuate class privilege are in direct contradiction with the health manpower goals of encouraging primary care practice espoused by the Congress and former HEW Secretary Califano. Such privilege is reflected in almost all the health professions (see Table 13).

Exacerbating the class bias, academic health institutions are inevitably biased toward reproducing themselves in their students, and their admissions policies reflect this. Among all applicants, 22 percent of those accepted but 31 percent of those rejected indicated interest in primary care, while 23 percent of those accepted and 19 percent of those rejected indicated interest in research (63).

The continuous MCAT and GPA inflation required of admissions also contradicts these national priorities, related as they are to family income (73). From 1976-77 to 1977-78 the proportion of A students (GPA=3.6 to 4.0) entering medical school classes increased 357 percent, while the proportion of entering classes with C averages (GPA less than 2.6) fell more than 80 percent (76), mirroring the growing affluence during the past decade of medical school classes (see Table 5, Part I). Grade inflation in high schools and colleges is widespread (53). It is epidemic at many prestigious institutions whose reputations rest in part on the ability of their students to compete successfully for admissions; at Harvard 85 percent of the 1977 graduates were given honors, compared to 39 percent in 1957 (76).

There is little question that minority students not only bear the burden of racial and cultural barriers to parity in the health professions, but disproportionately that of class (see Table 4, Part I). The controversy over admissions standards seems not to be one of maintaining quality but that of maintaining *race* and *class*.

"There has been a uniform and comprehensive effort to recruit and retain minority and women students and faculty in US health professional schools. Everything that can be done is being done."

Minority and women students. Were there indeed a real shortage of qualified minority candidates for the health professional schools, competition among the schools would lead to a relatively even distribution of minority students among predominantly white institutions. Nothing could be further from the present situation. Certain institutions have demonstrated a sustained ability

'The inadequacy of HEW's enforcement effort . . . permits the continuation of practices which result in the denial of equal education and employment to women and minorities.'

—US Commission on Civil Rights

Table

PLAYING THE 'DOZENS'—

BEST ENROLLMENT AND RETENTION

Under-Represented Minorities (Percent)

Medicine	Dentistry	Pharmacy
1. *Meharry* (86.2)	*Meharry* (84.0)	**Texas Southern*** (66.1)
2. *Howard* (75.8)	*Howard* (69.9)	**Florida A&M*** (59.9)
3. **UC-Irvine** (23.3)	*UC-Berkely* (21.0)	**Xavier*** (53.6)
4. **Stanford** (19.1)	*UCLA* (17.5)	*Howard* (45.2)
5. *New Mexico* (19.0)	*USC* (15.0)	*New Mexico* (23.8)
6. *UCSF* (17.9)	*Harvard* (12.7)	*Michigan* (14.7)
7. **CMDNJ-Newark** (17.9)	*Colorado* (11.3)	**Texas** (14.2)
8. *CMDNJ-Rutgers* (17.7)	*CMDNJ* (11.3)	*UC-Berkeley* (12.1)
9. *Michigan State* (17.4)	**M.C. Georgia** (11.1)	**U. Houston*** (14.2)
10. **Baylor** (15.4)	**Oklahoma** (11.1)	**Florida** (8.4)
11. **North Carolina** (15.0)	*Michigan* (9.1)	*Maryland* (8.3)
12. *Colorado* (14.5)	**Texas-SA** (8.3)	*USC* (7.8)

Women (Percent)

Medicine*	Dentistry	Pharmacy
1. **Med. Coll. PA*** (63.2)	*Harvard* (32.9)	*Puerto Rico* (75.9)
2. *SUNY-Stony Brook* (53.8)	*Puerto Rico* (26.9)	*Michigan* (66.0)
3. *Michigan State* (37.4)	*UCLA* (26.6)	**Purdue*** (53.4)
4. **UCSF** (33.9)	*Columbia* (23.1)	*Howard* (50.3)
5. *Howard* (33.8)	*SUNY-Stony Brook* (22.2)	**Tennessee** (50.1)
6. **Missouri-KC** (32.9)	*Meharry* (21.7)	**North Carolina** (48.9)
7. *Columbia* (32.9)	**Boston U.** (19.6)	**Virginia Commonwealth*** (47.3)
8. *Harvard* (31.5)	*Howard* (19.1)	**Kentucky** (47.2)
9. **Wright State*** (31.3)	*Tufts* (18.3)	**SUNY-Buffalo** (46.3)
10. *Tufts* (31.1)	**Connecticut** (16.9)	*Maryland* (45.9)
10. **UC-Davis** (30.9)	**Penn** (15.9)	*UC-Berkeley* (44.8)
12. *CMDNJ-Rutgers* (30.5)	*CMDNJ* (15.6)	**Illinois** (43.4)

*Indicates no other schools affiliated (e.g., an independent medical, dental, or pharmacy school). *Italics* indicate the appearance of the school in another best or worst category in this chart, indicating the frequent consistency and crossover between minority and women and between different schools (e.g., *Howard* appears in all best columns).

Source: Philpot, Wilbertine P., *Minorities and Women in the Health Fields: Applicants, Students and Workers*. DHEW Publication No. (HRA) 79-22, October 1978.

AFFIRMATIVE ACTION AND INACTION

WORST ENROLLMENT AND RETENTION

Under-Represented Minorities (Percent)

	Medicine[1]	Dentistry	Pharmacy
1.	S. Dakota (0)	*Emory* (0.2)	Northeastern* (0)
2.	*West Virginia* (0.3)	*Nebraska* (0.4)	Albany (0)
3.	Vermont (0.3)	Marquette (0.6)	Pittsburgh (0)
4.	Hawaii* (0.3)	Ohio State (0.7)	Iowa (0)
5.	Oregon (1.1)	Boston U. (0.7)	*U.Toledo** (0)
6.	Albany (1.3)	S. Illinois (0.8)	SUNY-Buffalo (0)
7.	S. Florida* (1.3)	*West Virginia* (0.8)	*Wyoming** (0)
8.	Virginia (1.4)	*LSU* (1.1)	Washington State* (0)
9.	*Tennessee* (1.5)	*Tennessee* (1.3)	Ohio Northern* (0.2)
10.	*LSU-Shreveport* (1.8)	Minnesota (1.7)	*N. Dakota State** (0.3)
10.	*Nebraska* (1.9)	Indiana (1.8)	Duquesne* (0.3)
12.	Nevada* (2.1)	Louisville (1.8)	*Idaho State** (0.4)
			Drake* (0.4)

Women (Percent)

	Medicine	Dentistry	Pharmacy
1.	*Creighton* (12.8)	*Tennessee* (4.9)	*Utah* (19.0)
2.	*Utah* (13.4)	*Creighton* (5.4)	*Idaho State** (20.2)
3.	Texas-SW* (14.1)	*Nebraska* (5.4)	*Oklahoma* (23.4)
4.	*LSU-Shreveport* (14.6)	Missouri-KC (5.5)	*Wyoming** (23.4)
5.	S. Alabama* (14.8)	*S.Carolina* (5.6)	Brooklyn* (24.1)
6.	*S. Carolina* (14.9)	Georgetown (5.7)	Ferris State* (25.1)
7.	*Tennessee* (14.9)	Baylor (6.1)	New Mexico (26.2)
8.	Miami* (15.3)	*Emory* (6.2)	NE Louisiana* (26.2)
9.	Minn-Duluth* (15.3)	SUNY-Buffalo (6.7)	*U. Toledo** (26.6)
10.	*Oklahoma* (15.5)	*West Virginia* (6.7)	St. John's* (26.8)
11.	Uniformed Serv.* (15.6)	Temple (7.0)	Samford*(Ala.) (27.9)
12.	St. Louis (15.8)	Northwestern (7.3)	*N. Dakota State** (28.3)
	West Virginia (15.9)		

Footnotes:

[1]More recent data from the 1978-79 academic year show virtually no change in the leading seven predominately white medical schools with only slight changes in their order and only two changes in the top ten such schools (77).

[2]More recent data for the 1978-79 academic year demonstrate that five medical schools had no minority students enrolled, including two newly opened schools. The dozen worst schools were virtually identical to those of 1976-77 with the addition of three newly opened schools (77).

[3]More recent data from the 1978-79 academic year demonstrate the stability of these rankings. The six medical schools with the highest percentage of women enrolled remained the same with slight changes in order. Ten of the top twelve such schools were among the top sixteen in 1978-79 (83).

to attract and retain under-represented minorities and women; others have failed or never even tried. It should come as little surprise that most of these schools that have been successful recruiting and enrolling minorities are the same that have admitted significant percentages of women, including all the predominantly minority health institutions (i.e, Howard, Meharry and Morehouse). No shortage of qualified women candidates has yet been identified, although the percentage of women entering medical schools actually fell slightly in 1978-79, for the first time since the early 1950s (76).

In the fall of 1978 five medical schools, one dental school and five schools of pharmacy enrolled no under-represented minorities at all! Eight schools of pharmacy in 1976-77 had no minority students enrolled

The New Jersey College of Medicine and Dentistry and Rutgers, UC-San Francisco and Irvine, Michigan and Michigan State and New Mexico have consistently maintained and graduated the greatest percentage of minority professionals in medicine, dentistry and pharmacy among the predominantly white schools. Three state systems—California, Michigan and New Jersey—represent a disproportionate number of the health professional schools with higher minority enrollments, while both West Virginia medical schools have *no* minority students (77). In the fall of 1978 five medical schools, one dental school and five schools of pharmacy enrolled no under-represented minorities at all! One Black dental student spoiled West Virginia University's otherwise perfect exclusion of minorities in its three health professional schools. These institutional policies cross over disciplinary lines, so autonomous schools of medicine, dentistry and pharmacy at one institution may consistently have strong or weak affirmative actions efforts (see Table 15).

Pervasive institutional attitudes are not limited to admissions policy alone but determine the content of what is taught. A survey of 113 medical schools showed that those institutions where ethnic and sociocultural issues were thought important enough to deserve formal courses in the curriculum were the same that had the highest minority enrollments; those that dealt with the assessment and treatment of minority group members in other courses had median enrollments, while those that had no teaching on sociocultural factors in medicine had the lowest minority enrollments (78). An earlier survey found that successful minority admissions was most closely correlated with modification of admissions procedures to include minority students and faculty (79).

The impact of the political environment is powerful, as can be seen from the list of successful and unsuccessful institutions (Table 15). The city of Newark, site of one of the worst urban riots of the late 1960s, has emerged with a potent minority electorate which has made demands upon its health professional schools. Similar settings in Chicago, Boston, Detroit and New York City have not had perceivable impact (see the comparative case studies of Newark's College of Medicine and Dentistry and New York's Sophie Davis Center for Bio-Medical Education by Richard Younge). The University of Connecticut, on the other hand, was built in suburban Farmington, insulated from Hartford and the mainland's third largest Puerto Rican population; it had no Puerto Rican students in 1976-77 (80). The University of South Dakota, demonstrating the "soft money" syndrome, states that "we feel that we have a special obligation to Native Americans" (80), while apologizing for having no funds to devote to a special program. No minority student has attended the school in any class since 1975-76 (77, 81)! The University of West Virginia, which has no affirmative action program, special recruitment or financial aid plans, had one Black dental student enrolled among its 623 health professional students in three schools in 1978-79. Eight schools of pharmacy in 1976-77 and five schools of medicine in 1978-79 had no minority students enrolled (77, 81). Despite its long-established reputation and 2,000 minority applications each year, Howard still maintains a vigorous recruitment program (82).

West Virginia, LSU-Shreveport, Tennessee and Nebraska ranked among the worst schools for the enrollment of *both* women and minorities in medicine and dentistry. Toledo, Wyoming, North Dakota and Idaho State shared this record among schools of pharmacy (Table 15). The institutional attitudes reflected in recruitment and admissions of minorities appear to parallel those toward women and are likely to be equally evident in what is taught about women.

A striking pattern emerges when examining

the medical schools enrolling the fewest women. Of the 30 schools with the lowest female enrollments, 21 are located in the southeastern and border states (77). Only one of the predominantly white schools with 30 percent or more women enrolled was a border state—i.e., Kentucky, Missouri, Tennessee and West Virginia. None were in the southeastern states in 1978-79 (83). This pattern is present but less prominent for minority enrollment, with 18 of the 33 lowest medical school enrollments to be found in the southeastern and border states (77).

Faculty. The participation of minority faculty and students in the admissions process has been the most important factor identified in successful recruitment efforts, according to a 1972 study (79). A survey of women medical students and practicing physicians ranked increasing the women in academic positions in medicine highest among a variety of choices for improving the situation of women physicians (84). Thus, a necessary condition for successful minority and female enrollment must be the recruitment of minority and women faculty. That 1972 national survey found that 65 percent of medical schools admitted that their efforts to recruit minority faculty had failed; half said that they had failed recruiting minority administrators. Only one percent of the American medical schools reached even 75 percent of their recruitment objective in faculty, while 35 percent noted success and only 11 percent failure in student recruitment (79).

Of the 30 schools with the lowest female enrollments, 21 are located in the southeastern and border states. Only one of the predominantly white schools with 30 percent or more women enrolled was in a border state. None were in the southeastern states in 1978-79

With the increase in minority graduates since that 1972 survey some improvement in recruiting minority faculty presumably should be seen. Nevertheless, the ivory walls remain

Table 16

Minority Representation on U.S. Medical School Faculties, 1971-72 to 1978-79

	1971-72[1]		1975-76[1]		1978-79[2]	
	Number	Percent	Number	Percent	Number	Percent
Caucasian	27,005	77.9	33,345	82.0	38,641	82.0
Black	565	1.6	732	1.8	820	1.7
Native American	11	†	14	†	22	†
Mexican American	54	0.2	74	0.2	89	0.2
Puerto Rican	263	0.8	276	0.7	320	0.7
Other*	2,432	7.0	3,622	8.9	3,445	7.3
Unknown	4,328	12.5	2,618	6.4	3,803	8.1
Total	34,658	100.0	40,682	100.00	47,140	100.0

†less than .05%

*Includes other Spanish surnames, Asian and Pacific origin

Sources:

[1]Jolly, H.P., and Larson, Thomas A., *Participation of Women and Minorities on U.S. Medical School Faculties.* Washington, D.C.: Association of American Medical Colleges, March 1976.

[2]Higgins, Elizabeth J., "Datagram: Participation of Women and Minorities on U.S. Medical School Faculties," *J Med Educ* 54: 252, March 1979.

white and impenetrable. Although the absolute numbers of Black, Hispanic and Native American faculty have increased since 1971-72, they represent the same 2.6 percent in 1978-79 as in 1971-72 (see Table 16). Even this standing in place was disproportionately contributed to by the predominantly minority medical schools—Howard, Meharry and Morehouse. The number of Black faculty increased 33 percent at Howard and Meharry from 1971-72 to 1975-76 but only 29 percent at predominantly white schools (85). Morehouse was established in 1977-78. The percentage of mainland Puerto Rican faculty has actually declined during the decade (see Table 16).

Although unique circumstances might be cited to justify the lack of progress in affirmative action on *medical* school faculties, in fact, medical schools are typical of all institutions of higher education. A 1975 survey of colleges and universities found that the proportion of Black faculty members had not changed during the previous decade (86). The percentage of Blacks was not greater among young faculty than among older age groups. Blacks were concentrated at less prestigious institutions, just as they are among medical and dental schools (62).

More than fifty medical school departments of anesthesiology, basic science, family practice, neurology, obstetrics-gynecology and radiology have no senior (tenured) women faculty at all

Recruitment of women on faculties of medical schools is only slightly less discouraging, despite the growing number of women enrolled and graduating. Nationally there has been no significant upward movement in the past ten years (87). In 1965-66 women represented 15 percent of faculty members holding medical degrees; in 1975-76 this was only 9.9 percent (88). Since 1975-76 the percentage of women on medical school faculties has remained just about the same—15.1 and 15.2 percent in 1975 and 1978, respectively. The largest number and percentage of these women faculty members, however, were found in libraries, where women comprised more than 70 percent of the staffs (83).

Women are also disproportionately represented in the lower faculty ranks (see Table 17). There are no women deans, only 4.5 percent associate and 9.9 percent assistant deans and 1.5 percent department heads, with no significant improvement in these figures during recent years (83). More than fifty medical school departments of anesthesiology, basic science, family practice, neurology, obstetrics-gynecology and radiology have *no* senior (tenured) women faculty at all (87). The largest

credit: **Dr. Martin Luther King, Jr. Health Center, Bronx, N.Y.**

single rank of senior women faculty is professor emeritus (13 percent), a tribute to an earlier era of the women's movement (87)! To make these matters worse there was between a $600 and $1,000 difference in salaries between men and women at the same rank noted as recently as 1975, although such salary differentials have been illegal in higher education since 1972 (88). One study at UC-San Francisco found a $7,000 difference between male and female doctors of the same experience and productivity (89). An HEW study commissioned in 1976 "did not find affirmative action efforts to be either significant or widespread" for women in all the health professional schools (63). Apparently health professional schools are more generous with seats in their classrooms than at their lecterns or in their laboratories!*

*Private practice has no better record. The average woman doctor in private practice earned a median income of $39,820, while her male counterpart earned $67,450 in 1978, a 41 percent difference which has not changed since 1974 (90). Much of this is attributed to the continued preference by women of the lower-earning specialties, especially pediatrics and psychiatry, over the more lucrative surgical specialties. Women physicians are also more likely to limit their practices to part-time.

Attitudes. Among southern Black undergraduates surveyed (49), a strong consensus emerged that their institutions needed to give special attention to recruiting Black faculty and administrators (88.6 percent agreed), yet were not making a sincere effort to do so (65.2 percent). They agreed (84.6 percent) that more concern should be given to minority student interest but felt that they had inadequate input into planning and organizing programs to serve their interests (57.3 percent). Most agreed (68.4 percent) that minority students should meet the same academic standards for admissions as other students while supporting special consideration in admissions to professional school (62.7 percent). The most important factor in recruiting future minority students they identified was increased financial aid opportunities, followed closely by increasing the number of minority faculty, staff and administrators (49).

Most telling were the differences in attitudes found between faculty and administrators involved in minority affairs and those in academic, student or financial affairs. Those administrators in business and finance consistently held the views most opposite those held by Blacks among all administrators polled on racial climate and the institutional responsiveness to, and the impact of, increased Black enrollments (91). These administrators' "bottom line" attitudes reflect the high financial aid price for affirmative action (see Part I). Not surprisingly, none of the institutions surveyed in that NIMH study (91) was making any explicit or visible attempt to shift minority program support from external sources to internal operating budgets, the "soft money" syndrome identified above.

An institution's reputation (49, 91) and strengths in the areas of the Black students' interests (91) were the most important factors in their choice of institutions. More important to future recruitment were the significant differences in what Blacks perceived as attractive and what whites thought would attract Black students (91). Even with such demonstrated differences, not a single institution surveyed had ever attempted to assess systematically what made a school more or less attractive to Blacks or how Black students' perceptions differed from those of whites (91).

Similarly, the attitudes of Blacks and whites on why there are not more minority or women faculty in the medical schools are dramatically different. Among the faculty, fellows, house officers and students polled at the University of Michigan, only one-third of Black respondents thought too few Black faculty were available, while 90 percent of whites believed this. *All* the Black students thought the attitudes of white

Not a single institution surveyed had ever attempted to assess systematically what made a school more or less attractive to Blacks or how Black students' perceptions differed from those of whites

Table 17

Distribution By Rank Of Male And Female Full-Time Medical School Faculty, 1976.

Rank	Percent of All Males	Percent of All Females	Percent Female
Professor	28	8	5
Associate Professor	23	16	10
Assistant Professor	32	36	16
Instructor	8	22	31
Lecturer and Other	6	14	28
Clinical Ranks	3	4	18

Source: Braslow, Judith B., "Current Status of Women in Academic Medicine," paper presented at the Regional Conference on Women in Medicine, New York, March 24, 1979.

Table 18

PERCENTAGE DISTRIBUTION OF NATIONAL HEALTH SERVICE CORPS PRACTITIONERS BY SEX AND ETHNIC BACKGROUND, 1979

	Total Number	White	Black	Hispanic*	Native American	Asian	Male	Female
Physicians	704	79.5%	11.0%	(10.9)%	0.2%	9.0%	76.7%	23.2%
1978 M.D. Graduates	14,393	87.7	6.0	2.8	0.3	2.5	78.6	21.4
Dentists	239	93.2	4.0	(10.5)	---	1.5	91.2	8.8
1978 DDS Graduates	5,177	91.1	4.2	1.3	0.3	3.1	92.9	7.1
Osteopathic Physicians	52	94.2	3.9	---	---	1.9	94.1	5.9
1978 D.O. Enrollment	3,671	95.6	1.9	0.8	0.5	1.1	90.7†	9.3†
Nurse Practitioners	214	93.2	4.6	(3.4)	1.1	1.1	13.2	86.8
Physician Assistants	110	88.6	5.7	(10.2)	4.5	1.1	75.5	24.5

*NHSC figures are for Spanish-surnamed practitioners who are also included under a racial group, largely White.
†Indicates 1978 graduates of osteopathic medical schools.

Source: Telephone conversation with Ms. Rae Loen, Asst. Director, Recruitment, NHSC, May 17, 1979.
Vetter, Betty M., Babco, Eleanor L., and McIntire, Judith, *Professional Women and Minorities: A Manpower Data Resource Service*. Washington,D.C.: Scientific Manpower Commission, November 1978.

faculty and housestaff turned prospective minority candidates off, while less than half the white respondents agreed with this (92). Throughout the survey, on almost every issue examined, Blacks and whites had almost opposite views (92). Blacks viewed whites' attitudes opposite to the way whites viewed themselves.

Solutions proposed by predominantly white institutions for under-representation, if these studies are any indication, are likely to embody attitudes sharply different from those of the minorities whom they are trying to recruit—unless there is considerable minority participation from its onset. This "designed-to-fail" Catch-22—where without minority members, minorities cannot be successfully recruited—suggests another reason why so many "good faith" efforts have had such limited results. Health professional schools for too long have exercised the power to decide what was "best" for minority students.

"There is no evidence that women or minority members would better serve the health needs of the nation than white males."

Despite numerous studies to the contrary, many in health academia still maintain that they cannot predict (and, thus, select) those applicants most likely to enter primary care in underserved areas in rural and inner city America. Typical of this attitude, L. Thompson Bowles, a dean at George Washington University School of Medicine, said, "Medical schools are not very good at picking and predicting which students will elect careers in underserved areas . . . none of us knows how to identify such students consistently" (18). Numerous studies in the 1950s and 1960s demonstrated conclusively the importance of rural rearing for physicians and their spouses who settle in small town and rural practices (41, 93). The location of the physician's medical school and post-graduate training was repeatedly demonstrated to influence those who choose urban practices (41, 93). White MDs tend to establish practices among their ethnic groups of origin, away from low income and non-white populations (94). Surveys of Black physicians show that they are relatively concentrated in general and family practice and other primary care specialties (95-97), and in practices which serve Black, economically disadvantaged and inner city

patients (98). Eighty-five percent of recent Black dental graduates in California had 50 percent or more minority patients, and 80 percent of those in Los Angeles and Alameda counties, more than half of the graduates, were located in or adjacent to federal shortage areas (94). Howard and Meharry graduates are three times more likely to serve in large municipal hospitals that serve mostly minority populations (96). Among physician assistant students, 35 percent of Black students, compared to one percent of white students, identified inner city ghettoes as their anticipated practice choice; half the Blacks from large cities anticipated ghetto practices (99).

Women and Blacks indicated significantly more interest in practice in physican shortage areas than men and whites, respectively, with similar but less dramatic trends for primary care in general (28). This interest has become a commitment to action, as minority and women health professionals are generally overrepresented among active NHSC practitioners (about half of whom are volunteers without service obligations) working in under-served shortage areas (see Table 18).

The relationship between socioeconomic class and specialty practice choice is perfectly linear. Janet Melei Cuca of the AAMC noted, "The connections between income, education and occupation have been so well established in the sociological literature as to have become almost axiomatic" (75). A direct relationship has been found between family income and both primary care specialty choice and interest in a physician shortage area; the higher the family income the more likely the choice of specialization and the less likely the interest in a shortage area practice. This was true both within and across ethnic and sex groups. Those anticipating larger debts on graduation consistently showed greater interest in physician shortage areas than those anticipating no debt (28). More recent data show the continuation of these trends (100). Long term confirmation comes from the AAMC longitudinal study of 1960 medical graduates; those graduating from schools with lower MCAT scores—and consequently lower socioeconomic class backgrounds—were more likely to enter primary care (41).

There can be little doubt that admitting greater numbers and percentages of women and minorities, especially from disadvantaged backgrounds, will result in greater numbers of primary care practitioners locating in underserved communities. This is particularly important for those communities where access to care is also limited by cultural or language barriers—in the barrios, the Chinatowns, the "J-towns" and on and off the reservations.

"The federal government is doing everything in its power to support affirmative action in the health professions."

At the request of Congressman Ronald Dellums of California, the General Acconting Office investigated HEW's record on affirmative action. The GAO concluded that HEW had "made minimal progress in making sure that colleges and universities have acceptable affirmative action programs," having failed to send "show-cause" notices or begin sanctions against noncomplying institutions, conduct pre-award reviews or enforce even publicized plans (101).

A direct relationship has been found between family income and both primary care specialty choice and interest in a physician shortage area, the higher the family income the more likely the choice of specialization and the less likely the interest in a shortage area practice. This was true both within and across ethnic and sex groups

The House Subcommittee on Equal Opportunity found academic institutions to deserve no special exemption from the Executive Orders which regulated federal contracts and noted that enforcement of equal opportunity had been ineffective and federal contract compliance deficient. The US Commission on Civil Rights found in 1975 that "the inadequacy of HEW's enforcement effort . . . permits the continuation of practices which result in the denial of equal education and employment to women and minorities." HEW was again criticized for its reluctance to issue show-cause notices to noncompliant institutions; from 1971 to 1974 despite uncovering numerous violations, only two such notices were issued. HEW repeatedly accepted the assurances of institutions and "plans for a plan" rather than the accepted standard of a documented plan for affirmative action (15). Jack Hartog, an attorney for the

Commission on Civil Rights, called the HEW affirmative action effort "a disaster." One of the rumored reasons for former HEW Secretary Joseph Califano's departure from the Carter Cabinet was his effort to push HEW to fulfill its mandate and enforce the laws regarding equal opportunity in southern university systems.

HEW maintains an Office of Health Resources Opportunity, but its activities did not even merit discussion in the General Counsel's review of the department's activities in light of the *Bakke* decision (102).

The GAO did not even address the issue of the quality of data collected. The problem arises because the data necessary to monitor affirmative action programs are gathered from the institutions to be regulated and contain many subtle and hidden biases. Just one example is the AAMC's inclusion in first year enrollments all repeating minority students, rather than just newly enrolling and matriculating students, which inflates the apparent size of the "incoming" minority students by ten to twenty percent most years (9; see also Part I). This not only misleads but results in overlooking some remarkable findings—that 17 percent of minority students offered admissions in 1973-74 to medical schools failed to enroll, something which has never occurred to this extent among white acceptees (9). Some 224 qualified and admitted minority applicants just disappeared, and no one asked any questions because they were "lost" in the statistics!

The US Congress, as we have seen, weakens affirmative action with various amendments and anti-bussing riders. An HEW-commissioned study on women in the health professions concluded that the Congress' health manpower actions "seem not to consider, as a matter of course, their possible or probable impact on the entry or practice of women in the professions. . . . We found that some elements of these policies counter much of the intent of affirmative action retention efforts—that is, the weight of manpower policies is far greater in impact than the weight of affirmative action efforts" (63). This, of course, is just as true for minorities.

What cannot be accepted as fact is that health manpower and affirmative action needs are contradictory. They are, as has been shown above, quite complementary, even necessary.

The specific solutions chosen for resolving the specialty, geographic and language/culture maldistributions have served to exacerbate rather than resolve minority and women's under-representation in the health professions. This is, unfortunately, the natural consequence of the class interests and ideology of the federal government, the health professions and their academic institutions. Their myths are designed to disguise genuine contradictions and create them where they have never existed.

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